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ABSTRACT

The first part of this report on alcohol and drug abuse summarizes major recommendations from testimony and written statements from a hearing on alcohol and drug abuse. Testimony from these witnesses is included: (1) Reed Bell, Director, Office of Substance Abuse Prevention, United States Department of Health and Human Services; (2) Merita Thompson, Department of Health Education, Eastern Kentucky University; (3) James Neal, Director of Prevention Services, South Carolina Commission on Alcohol and Drug Abuse; (4) Beny J. Primm, Executive Director, Addiction Research and Treatment Corporation, Brooklyn, New York; (5) H. Leonard Boche, Executive Director, Minnesota Association of Treatment Programs; (6) David L. Armstrong, Attorney General, Commonwealth of Kentucky; (7) Alex Brodrick, Executive Director, Volunteers of America, Louisville/Lexington, Kentucky; and (8) Andy Devine, Juvenile Judge, Lucas County Juvenile Court, Toledo, Ohio. The second part gives the background of prevention strategies, sets forth the rational bases from which today's prevention strategies are derived, summarizes models to guide new efforts and provide a framework for analyzing common problems, and suggests specific guidelines for planning strategies to prevent alcohol and drug abuse. The third part provides summaries of alcohol and drug abuse programs arranged by state and includes a contact person's address for each entry. The fourth part lists additional resources, including program listings and reports on special topics. (ABL)

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Task Force on Alcohol and Drug Abuse

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TABLE OF CONTENTS

Acknowledgements		1
PART ONE:	**The Task Force**	3
PART TWO:	**Alcohol and Drug Abuse Prevention: From Knowledge to Action**	25
PART THREE:	**Alcohol and Drug Abuse Prevention Programs in the States**	53
PART FOUR:	**Additional Resources**	77

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Of course, in trying to think of the numerous people who helped us in the project, someone's name will not be mentioned due to oversight. For this, we apologize.

PART ONE: The Task Force

TASK FORCE ON ALCOHOL AND DRUG ABUSE
Public Hearing
January 28, 1987, Lexington, Kentucky

Introduction

Kentucky Gov. Martha Layne Collins, chair of the Task Force on Alcohol and Drug Abuse, convened a national public hearing in Lexington, Kentucky, on January 28, 1987. Joining Gov. Collins were representatives of other Governors on the task force, including Dr. Robert Brock, Michigan; Dr. Richard Freeman, Rhode Island; Bruce Marshburn, North Carolina; and Thomas F. Miriello, North Carolina. Several Kentucky agency officials also participated, including Al Austin, secretary of the Cabinet for Human Resources; Dennis Boyd, commissioner of the Department of Mental Health and Mental Retardation Services; and Norma C. Miller, secretary of the Justice Cabinet.

At the hearing, the task force sought the advice and counsel of substance abuse experts with a view toward hearing their recommendations for education and prevention, early intervention and treatment, and law enforcement strategies that states can use to address alcohol and drug abuse.

This summary presents major recommendations from excerpts of testimony provided at the hearing; and written statements submitted for the task force's consideration subsequent to the hearing.

Dr. Reed Bell, Director, Office of Substance Abuse Prevention, U.S. Department of Health and Human Services

The federal government responded to the problem of community drug abuse with congressional passage of the Anti-Drug Abuse Act of 1986. President Ronald Reagan signed this act into law on October 27, 1986. The act created the Office of Substance Abuse Prevention as part of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) to complement the National Institute of Alcohol Abuse and Alcoholism (NIAAA), the National Institute of Drug Abuse (NIDA), and the National Institute of Mental Health. All of these agencies are within the U.S. Department of Health and Human Services.

OSAP is located organizationally within the office of the administrator of ADAMHA and is interrelated through that office with the treatment and prevention research that has gone on for years in the other institutes which provide an excellent resource for OSAP. OSAP uses this base of information to improve its efforts to prevent drug abuse.

After the law was signed the office held a National Strategy Conference. This is one of the first times that the federal government has elected to invite the "grass roots" to come and help formulate appropriate strategy nationally with an eye toward making prevention not only a new trial but a new success. About 200 people attended the conference in Washington on December 15-16, 1986. Different areas of substance abuse and prevention were addressed. This discussion led to the structure of the office. The Office of the Director supervises four division operations: Information Services, Community Assistance, Demonstration Programs, and Evaluation and Research.

Information Services. This division sorts out and integrates the clearinghouse activities of NIAAA, NIDA, and other related substance abuse programs. It provides an effective source of information on substance abuse through data bases and a telephone service. The division also includes a publications unit that reviews all publications, improves them, and tries to make them available to communities. In addition, the unit handles media and public affairs, which includes an effort to use media personalities and entertainers to promote substance abuse prevention efforts nationally.

Community Assistance. This division will facilitate work being done at the community level. The division will focus on four groups: parents, youth, schools, and minority groups. Active parents at the community level are a key factor in determining the effectiveness of prevention programs. Youth are the second priority, based on the impact they can have on community substance abuse prevention efforts. There is excitement about youth -- their idealism, their openness -- and about mobilizing them in prevention efforts. They are willing to listen to anti-drug messages. The third priority area is the schools. OSAP is working actively with the Department of Education to make its research base available throughout the education system. The fourth area will focus on minority groups, especially high-risk populations. An ombudsman for minority interests and groups will serve within the office of the director.

Demonstration Programs. This division was mandated under the law and will be a $24.5 million program aimed at identifiable, high-risk groups. There will be three grants under this effort: one targeted to comprehensive systems within the community; a second targeted to at-risk populations; and a third targeted at prevention and early intervention. The division is looking for community-based programs with demonstrated effectiveness in prevention and intervention techniques to use as models in other communities. Much of this division's work will be devoted toward evaluation and research of those particular efforts to discover what seems to work and what can be done better.

Evaluation and Research. This division will focus on the findings of prevention research carried out by the institutes. This information must be available to the agency and then made available to communities so that the problems of prevention can be addressed more effectively.

The Office of Substance Abuse Prevention has $42 million for recognizing not only what works in prevention, but to serve as a facilitator in helping those at the community level. Of course, $42 million is not enough to carry out national prevention programs. The organization, though, is structured to assist states and communities that are addressing these problems. In a real sense, OSAP is a special office, of prevention, and to address this issue it will work with states and communities in every way in terms of information resources; in terms of information resources; in terms of community assistance; to schools, to parent groups, to youth groups, to minorities, and to special interests; and in terms of research and evaluation.

The operative philosophical blueprint for developing prevention strategies divides the substance-abusing populations into categories of "easy" and "hard" and the "older" and "young." These divisions are reflected in the schema below.

	Easy	Hard
Young	Just Say No	High Risk Youth
Old	Workplace (20-40 years of age)	Chronic Addiction

The workplace effort, focused roughly on persons 20 years to 40 years of age, has been assigned to the National Institute of Drug Abuse. This agency is working on the implementation of a drug-free workplace initiative. Prevention efforts will focus on normative values in the workplace -- alcohol and drug abuse shouldn't be tolerated, particularly where they create safety problems, performance problems, and, of course, health problems.

For some of the young group, there is the "Just Say No" effort. It is readily apparent that for a large percentage of the young people, this is the right message.

Then there is a segment of high-risk youth who are considered difficult to serve. A "Just Say No" message cannot simply be offered to this population. More active interventions are needed.

Finally, there is the older, hard-core narcotics population that has very serious substance abuse problems. Efforts directed at these individuals also are being addressed by the National Institute for Drug Abuse.

Dr. Merita Thompson, Department of Health Education, Eastern Kentucky University

Within the context of substance abuse prevention programming in schools, it is important to recognize that we must look at schools with an eye to their relationship with the rest of society. Schools have a key role to play, but they often have been given too much blame for the problem and too much responsibility for the solution. When you consider the possible impact of all the other influences on a child's life, we cannot be surprised when classroom programs often do not show immediate and drastic results. All of us will have an impact on the life of a child, and school has a role to play, but it is a part of a larger picture.

By now, most major newspapers in the country have carried articles on the fact that we have few drug prevention programs or schools that are proven to work. In reality, when one examines the hundreds of studies that have been conducted to determine the effect of various programs and approaches, most of the programs or evaluations are so flawed in design or implementation that the safest statement we probably can make is that we have a lot to learn about what is best and what works well, and drug education truly is in its infancy. Substance abuse prevention programs, including those in schools, can fail in a number of ways, and it is important to look at those as we consider what we understand about prevention programming for schools -- first in concept, then in operations, then in implementation, and finally in evaluation.

Any program that is conceptualized without thought given to distinct populations and their different needs and receptivity will be destined to have results that, at worst, fail, and at best, are skewed or distorted. We must learn to plan for the different populations in any classroom in order to expect the results that we are hoping for.

When programs are based on the theory that knowledge equals attitudes equals behavior, they may err in many ways. We don't always know what knowledge results in what attitudes, or what attitudes result in what behaviors.

In operationalization, knowledge selected in a program is very critical. It must be sufficient to make people perceive they are at risk. For example, some curriculum guides spend time discussing

how beer is made, although that information probably doesn't help people make decisions about their own choices regarding alcohol consumption.

In implementation, time is of critical importance. We know from research and experience that programs that are more intense, that are longer in duration, tend to have better results. Yet, we have programs that are very short, that are spattered and spotted, and would have no logical sequence. The sequence of experience is very important. The readiness of a child at different levels is a critical issue in choosing information and activities that will make that child perceive himself or herself to be at risk. Inadequate teacher training in affective areas can lead to disastrous results.

In evaluation, possible errors are too numerous to mention: there are problems with cross-sectional versus longitudinal design; variables that are not controlled; evaluation instruments that do not reflect content; and, particularly, behavior related to substance abuse that is not being evaluated. One of the more important conceptual errors that also is an evaluation error is that other influences may play a much more powerful role than what we are doing in the schools.

Major reviews of hundreds of studies have been conducted, and most studies have been found to be flawed in one or more of these four areas, in such a way that logical, valid conclusions cannot be drawn from them.

Is the logical choice then to throw up our hands and in frustration and cynicism, say drug education does not work, and do nothing? No, we can't just wait until we understand the phenomenon to do something about it. We have to take our best shots now.

We can proceed based on, at least, observation and experience, research into the etiology and correlates of drug abuse, and findings on what has worked in acceptable research that we do have. We can proceed and we must proceed in the schools. The importance of beginning any effort with a plan for evaluation cannot be overstated.

To look, then, at what schools can and should do in the area of substance abuse prevention, these goals should be addressed:

- to delay the onset of use of substances;
- to provide information and skills that will enable students to make low- risk, healthy decisions now and later in life; and
- to provide a process for effective intervention with high-risk, drug-abusing students.

Schools also should contribute to the development of a healthy self-image that is sufficiently positive to enable a student to apply the information skills he gains in school. Schools can't take full responsibility in that, but they have a contribution to make and a role to play. Needless to say, these latter goals are appropriate also for faculty and staff at schools.

Our best shots in realizing these goals based on what we understand at this point in history, and knowing that we are in infancy in research and understanding in many ways, are these:

- First, there must be a planning process in schools that includes a team of people made up of school personnel and representatives from community leaders, parents, and substance abuse professionals.
- Second, the planning team, the superintendent, and the school boards should take a global view of prevention programs for schools. Curriculum and classroom instruction are important. But so, too, are policies that are fair, consistent, and well-understood by students, personnel, and parents, and that support the goals of prevention and intervention.

- Third, a good prevention program also will provide for education for all teachers and others in the school who have an impact on youth. Over time, in-service programs can reach all school personnel if the commitment is there. The school can conduct or actively support drug-free alternatives for young people, including recreational alternatives.

- Fourth, perhaps no component will be more important than parent education. Of the correlates of drug abuse, most of them involve the parent. If there are social correlates, most of them relate to the parent -- parent involvement, parental drug abuse, parental expectations, etc.

Every school has a population that is at high risk for drug abuse, and schools need intervention plans. Some student assistance programs have been found to be very effective with the high-risk population -- kids who are children of alcoholics, low-achieving youngsters, kids who don't fit in, and others. In addition, any good curriculum will result in identification of young people who are abusing drugs in high-risk ways and need help and intervention.

It's not enough to react only punitively to their behaviors. Through personnel planning, comprehensive discussion and planning of a process, and networking with parents and community resources, any school in the nation can provide some degree of help and intervention to these high-risk young people.

To truly evaluate a school prevention program is one of the most important needs. A data base must be established and monitored continually for changes. And this needs to be done at the state level and the community level.

The ultimate criterion is behavior. We will never really know about the efficacy of our school programs until we monitor drug-related behaviors. But interpretation of such data must always be tempered in reference to the school, with a realistic look at other influences on student choices, and especially the prevailing attitudes and behaviors in the adult community.

The backdrops of a sound academic program and positive school climate are very important. A sound, success-oriented academic program, in fact, may be the single most important component of a substance abuse prevention program. Kids who achieve in school, expect to do well in school, and have academic goals have significantly lower rates of substance abuse. A positive climate in which a child feels valued and free to create and explore his or her own decisions is absolutely essential.

Curriculum is what most people think of when they think about prevention programs in schools -- sequential, integrated, well-planned to be appropriate at appropriate times and in appropriate ways. One avenue of drug education is drug information. Factual information often has been used alone as the sole prevention effort. It often has been presented with a backdrop of moralizing or scare tactics. It often has been selected and presented with no thought given to the target subgroups in a classroom. And it often has been selected with no thought of its relative relationship to behavior. Information is not the baby to be thrown out with the bath water. People need factual information to help them perceive the risks and to understand their alternatives. It can have a cumulative effect over time, and we haven't measured that well.

Building self-esteem has not been researched very well in relationship to specific drug-using behaviors. But building self-esteem has been shown in many studies to evidence a decrease in absenteeism, delinquency, and other cluster behaviors that are correlates of drug abuse. Time, good planning, future training, and commitment can make this a valuable contribution to a school program. Skill building in these areas has a new promise on the horizon, and the studies are encouraging. The relationship among some of these efforts, especially assertiveness skills, peer refusal skills, and decreasing smoking and decreasing alcohol use and marijuana use, especially at some grade levels, is very heartening. We need to continue to monitor that, to continue to explore, to continue to evaluate, for these other areas can also make a contribution to the school program in

valuable ways. Kids who have a direction tend to use substances less often, and thus career education and self-improvement areas potentially can be important.

Decision making has a large base of support in health education literature. We don't know exactly the best techniques to bring the best results in terms of teaching decision-making skills. But it is essential that we move into that area. People do need decision-making skills. They need problem-solving skills, and we can find the ways and evaluate the ways to best teach them.

Our best educational approach is to incorporate as many of these as we can and not jump on the bandwagon of one and exclude the others. Major points to keep in mind include:

- Information about drugs is probably best done in combination with skill building in these areas and self-esteem building, especially at the lower grades.

- Students must have sound information to help them perceive their risks if they are to choose wisely over time. However, information often is not enough by itself, and decision-making and peer relationship skills are needed. A positive self-image will help them apply what they learn and enact the decisions they choose.

- We need to teach all of these, while continuously evaluating what we are doing and monitoring the research as it is being reported.

- Schools may purchase a program or choose to build their own curriculum, and there is value in both. It is very important that the team planning be a part of that. Colleges and universities need to provide information and skills for their general student body much as the public school does. We are finding some interesting things about what they don't do in that area. From all indications, substance abuse information for the general college population is at best three to four hours in a health class, and, commonly, it is nothing at all.

Evaluation is lacking. It is needed in behavioral terms on college campuses, and it goes sadly lacking on most. As with the local schools, colleges and universities need to establish a data base that could be used for decision making and for evaluation; an intervention plan that ideally would include a student assistance program; and a drug awareness program, not only for staff but for faculty, also. It would be very helpful for a campus to have inservice programs for faculty and other personnel. There is a surprising amount of ignorance among these individuals regarding substance abuse among their students. And student housing staff probably do it best, but there is a great need there.

Sadly, colleges and universities play a key role in another area, but don't often meet that very well. They are charged with preparing professionals, especially in human service areas that require a sound background in substance abuse. Most schools have never conducted a campus study of the adequacy of substance abuse education for these professionals. Institutions of higher learning need to assume more of a role in alcohol and drug abuse prevention research. That is within their role and certainly the need is there.

James Neal, Director of Prevention Services, South Carolina Commission on Alcohol and Drug Abuse

Each state has a designated lead agency for alcohol and/or drug abuse that is a member of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). Collectively, this group contributes to major governmental efforts to prevent and treat the problems resulting from the abuse of alcohol and other drugs.

NASADAD has recently recommended a strategy to reduce the demand for alcohol and other drugs. It is a multifaceted strategy that calls for:

- greater access to drug and alcohol treatment services;
- a major commitment to comprehensive drug and alcohol prevention education programs in our schools and in our communities;
- greater public awareness and education that treatment and prevention programs are available;
- more utilization of the well-established state networks for treatment and prevention programs; and
- expansion of private and public third-party reimbursement for treatment services to encourage greater participation by the private sector.

Treatment is included as part of a prevention or demand reduction strategy. This is because NASADAD, as well as many of its individual members, uses a public health concept of prevention. This concept recognizes a continuum of services, and not sharp distinctions between primary prevention, intervention, and treatment. Treatment, hence, is a vital part of prevention because of this concept, and also because of the population of users that consumes most of the alcohol and other drugs. For example, we know that there is a direct relationship between the amount of alcohol available in society, the amount consumed by the population, and the incidence of alcohol-related problems. Since about 20 percent of the alcohol-using population consumes almost 80 percent of the alcohol in this country, and this population presents the major concerns for treatment, we also reduce the demand for the drug by treating these individuals and by having early intervention programs.

The National Prevention Network (NPN) is an arm of NASADAD made up of the designated state prevention coordinators from each state and territory. NPN recently addressed letters to the Alcohol and Drug Abuse Mental Health Administration, the U.S. Department of Education, and the U.S. Department of Justice calling for the development of a national prevention strategy that would include several elements. First, the letter calls for a five-year prevention plan. It appears that our response to the problems resulting from the use and abuse of alcohol and other drugs moves from year to year, from drug to drug, and from population to population. That is not the way to do good prevention planning. It is not the way to measure our results. So, it is essential for good long-range planning in prevention to take place that recognizes that the drug scene does change, but that there are some components that take time to put into place and to measure.

Second, this letter calls for the creation of a comprehensive system for prevention in schools and communities, with emphasis on communities. We seem to have a tendency to want to focus all our prevention efforts on adolescents within the schools because they are the easiest population for us to target. We tend to forget that there are other communities that exist around schools. We also tend to forget that we have about a 26 percent dropout rate in this country, so many adolescents who are at the highest risk for abusing alcohol and other drugs are not in schools. Hence, we need to recognize that we don't need an approach to the prevention of abuse of alcohol and other drugs that focuses solely on the school population. We need a community approach that recognizes school dropouts and other high-risk groups within the community, such as the elderly.

Other components the approach calls for include:

- A consistent review of the funding process between the federal and state governments because we tend to operate in isolation with different parts at each level of government going their own way.
- Use of existing networks because there are now many networks that are in possession of a great deal of information and experience and are very willing to work in this area.

- A balanced approach between alcohol and other drugs. The most recent efforts on the part of the federal government have once again tended to focus on the so-called illicit drugs. While these are certainly major concerns, we need to recognize that in this country our number one drug of abuse has always been and still is alcohol. Hence, we need to have a balanced prevention approach that addresses alcohol as well as other drugs.

- A commitment to increased intervention and treatment services.

- The adoption of a continuum of care concept.

- The creation of advisory bodies. We particularly recommend that states create a state-level supply/demand reduction task force that would be composed of representatives from agencies that are concerned about the supply of alcohol and other drugs and how such substances get into society; representatives from health and human service agencies that are involved in reducing substance demand; and representatives from citizen groups that are actively involved in this field.

- Comprehensive training and technical assistance programs.

- A heightening of public awareness of the greater availability of effective prevention and treatment approaches.

The objectives of alcohol and drug abuse education and prevention initiatives are to:

- develop critical thinking skills and self-competency skills;

- provide specific information about alcohol and other drugs;

- instill information about healthy lifestyles;

- increase self-awareness;

- build self-esteem;

- impart interpersonal relationship skills;

- inform the advertising community about alcohol and drug abuse and help this community recognize the influence they have on personal decisions regarding use;

- communicate information about the supply of alcohol and other drugs and the impact that this has on other public policies;

- promote public policies that support healthy lifestyles; and

- promote peer resistance skills.

The human body doesn't make any distinctions as to whether or not it has ingested an illicit drug or a legal drug. Therefore, in some ways our prevention efforts need to clearly state that a drug is a drug. However, in other ways, some distinctions must be made because our society recognizes alcohol is frequently treated differently from other drugs. We also tend to treat nicotine and caffeine differently from other drugs. We need to recognize these attitudinal and public policy distinctions when we are planning prevention programs.

The South Carolina Commission on Alcohol and Drug Abuse is an independent state agency governed by a board appointed by the Governor and confirmed by the Senate. This commission

recently adopted an Alcohol Policy Bill of Rights, which addresses many of the distinctions in preventing the problems resulting from the use of our legal drug -- alcohol.

The Alcohol Policy Bill of Rights is based upon four principles:

- that abstinence is always an acceptable choice;
- that alcohol consumption considered to be high risk is actively discouraged;
- that alcohol consumption considered to be low risk is acceptable; and
- that heavy alcohol consumption is discouraged in all situations.

Now, based upon those four principles, there are some six rights within the Alcohol Policy Bill of Rights:

- The right to warning and beverage ingredient labeling so that consumers know the potential health risks of alcohol consumption; prominent displays of information; and elimination of misleading alcohol advertising or equal time for public health counter-advertising.
- The right to safe communities and roadways, including certain and swift enforcement of driving while under the influence laws; mandated server intervention programs and liability information; local and state alcohol beverage regulations that would control the number, location, and types of alcoholic beverage outlets; adequate funding of alcoholic beverage control commissions; and insurance incentives for safe and sober driving.
- The right to health-enhancing alcohol pricing, which uses adequate tax increases to discourage high-risk alcohol consumption, and equalized tax rates for all forms of alcoholic beverages;
- The right to protect our youth by having adequate funding for alcohol prevention education programs; adequate enforcement of the minimum purchase age law; and an end to alcohol consumption promotions aimed at youth, particularly those promotional activities on colleges and university campuses;
- The right to safe workplaces, to put an end to the pressure to use alcohol as a part of conducting business and the federal tax subsidies for corporate alcohol use, adequate funding of employee assistance programs, and an end to government subsidies for alcohol within the Armed Forces.
- The right to health services, the right to effective, low-cost recovery services available to the entire public, and assistance programs that would look at financial reimbursement and emotional and medical support for the victims of alcohol-related incidents.

The components of an effective alcohol and drug education prevention strategy should be under a public health concept that recognizes primary, secondary, and tertiary prevention, but also recognizes the agent, the host, and the environment, and the interrelationship among those three. We tend to focus most of our efforts toward the host by providing information and self-esteem building, self-awareness, self-competency, coping skill and decision-making skills, and ignore the environment in which those decisions take place. Hence, I think developing peer resistance skills or social resistance skills, or what some people call inoculation skills, becomes a very, very important part of host approaches to prevention. But, until we begin to look at policy issues that influence the environment, the supply of alcohol and other drugs, and how people make decisions when they relate to their environment about the use of alcohol and other drugs, then we have not really developed a comprehensive strategy.

A tremendous amount of research has been done on effective prevention approaches to the abuse of alcohol and other drugs, and new prevention strategies are always being discovered. We know a lot about what works, and perhaps even more about what does not work in alcohol and other drug abuse prevention.

Certainly, prevention programs that have been directed toward the schools provide a great deal of information. We know, for example, that the approach that grew out of the Harry Anslinger era of the thirties and forties, and moved onto the fifties and sixties, of trying to approach the problem by providing information, and particularly information that had sort of a moral slant to it, does not work. We know that information alone does not, in itself, change behavior. Information, though, is the basis for changing behavior and hence is a very critical part of any approach to primary prevention.

In alcohol and other drug prevention fields, we seem to have moved, particularly in the schools, to trying to combine information with effective education approaches. The idea, here, is that if we give young people information about a drug and then combine that information with some experiences around decision making, then the student will make the right decision. The prevention research has not shown that always to be true. This research is not in and of itself an indictment of affective education approaches. It is more of an indictment about our state-of-the-art in prevention and attempts to evaluate something as complex as human behavior and decision making.

There is another ingredient that is now appearing in substance abuse prevention strategies, that started with smoking cessation programs but is now being applied to alcohol and other drugs. This is delaying or preventing the onset of use through the development of peer resistance skills. The "Just Say No" movement is part of that concept of saying no to drugs – "Be Smart, Don't Start, Just Say No."

The research on peer resistance skills stresses the importance of being able to rehearse situations in our minds or with other people so that when we are confronted with the situation, we are more likely to say no. Hence, peer resistance skills are now part of the state-of-the-art knowledge about alcohol and other drug abuse prevention.

There is a step, though, that has to occur beyond just saying no. Individuals need to know why they want to say no and be able to articulate these values that support the decision. It is not enough to be able to say no to drugs because that may not last.

Part of the state-of-the-art in alcohol and other drug abuse prevention has to be related to the health promotion/public health movement. More and more we are beginning to address our lifestyles and look at things like smoking, eating habits, and dealing with stress. What is the appropriate government role in this field? The easy answer, of course, is to say that the appropriate role of government is to provide more funds and more resources. There is, however, much more that government can do. It is also a question of leadership and policy development. Specifically, government has a responsibility to be a leader in examining public policy and the promotion of supply/demand reduction. We need, for example, as part of our examination of public policy to review the role of ABC commissions in this country; are such commissions oriented toward protecting the public's health and safety, as was their original mission, or are they simply serving as tax-collecting arms of state government?

Government also can have greater influence on universities and colleges, particularly the state-funded institutions. We must look at ways to get state-funded institutions to incorporate training on alcohol and drug abuse into their professional degrees. We do a terrible job in that area. It is a shame that every state-supported institution doesn't offer a course on alcohol and drugs for students, but, more importantly, offer training for people who are going into the professions.

So, too, it is important for state government to establish supply/demand reduction task forces. For too long in our field, the people who have been involved with supply and interdiction have sat

on one side of the room, and the people who have been involved with demand reduction have sat on the other side of the room. We need to move away from this artificial distinction. The problems of alcohol and other drugs is one that needs the combined efforts of persons who are concerned with reducing the supply, as well as persons who are concerned with reducing the demand. These persons need to work together.

All populations are in need of information. Our health education efforts should not discriminate yet, we need to recognize that there are some parts of our population, such as children of alcoholics, that are at higher risk than others in terms of the abuse of alcohol and other drugs.

Schools can address this through student assistance programs that incorporate the identification of high-risk populations into their goals. Every high school should have a student assistance program that provides the administration with an alternative to the traditional sanctions that are imposed when a student is caught in possession of or under the influence of alcohol and other drugs. Student assistance programs allow for the student to be referred to a program that provides an assessment and appropriate education or treatment services. Every school also should have an employee assistance program to go along with a student assistance program, because while students have problems with alcohol and drugs, so do faculty and staff.

There is a need, then, to recognize subpopulations, such as children of alcoholics, the elderly, and populations that may be more prone to use and abuse of over-the-counter drugs. These subpopulations need to be taken into account when designing programs.

Dr. Beny J. Primm, Executive Director, Addiction Research and Treatment Corporation, Brooklyn, New York

An article in *USA Today* indicated that alcohol and drug abuse ranked number two for mental health admissions in this country. This reflects how important this particular field is. What influences alcohol and drug abuse admissions is unemployment. When unemployment is high, alcohol and drug admissions to mental health institutions are great. When salaries are low, when there is a period of recession, admissions to alcohol and drug abuse mental health facilities are greater. So, it is tied in with economics and even sociological factors. Another factor all over our country is closing wards and mental health institutions. In New York State alone in 1987, there will be 7,000 people from mental health institutions who will be let out on the street. A number of them become homeless: there are no places for them to go, and many certainly fall or succumb to the problem of substance abuse on the street. Currently, only 100,000 people are in mental health institutions, and this year the number will be reduced to far less than that.

Stress, too, is related to substance abuse. We have stress every day when we wake up, if we're cold, if we're hungry, if we have problems with our work or unemployment, or too little of this or too little of that. Most of us know how to cope with that stress. But many of us are never taught how to cope with stress. And as a consequence, we end up falling prey to, of course, substance abuse.

One would think that stress is the lead reason for counseling, but it ends up being substance abuse. This is another reason why states must do something about the treatment of substance abuse. It is readily apparent how alcohol contributes to the poor health of all of our citizens. In New York City, it is the fifth leading cause of death of everyone. In my community (black), it is the second leading cause of death. The first leading cause of death is AIDS. The third leading cause of death in my community is homicide. The fourth leading cause of death is drug dependence.

The use of crack is a serious problem in some communities such as New York. But if it's in New York, it's going to be in your state sooner or later. It's just a matter of time. We are now seeing kids buying crack at 10, 11, and 12 years of age. They smoke it on marijuana cigarettes or smoke it on other cigarettes. Crack is a smokeable form of cocaine that gets to the brain in eight to ten seconds, or less. The high is intense and rapid. It lasts three to five minutes, which means people end up having to buy drugs very frequently. The crash is very intense so they need a

parachute drug to come down; they will likely take something like cognac or a heavy-bodied liquor or one of the sedative hypnotic drugs to ease that crash. There is an intense craving secondary to taking this drug and a rapid addiction, with severe medical and psychiatric problems resulting.

There is a treatment for cocaine-related problems, although there is no specific treatment for crack. One thing to do is to take people away from the availability of the substance. There are some chemotherapeutics that are being touted now as being helpful in the problem. But, if you introduce someone to another type of drug, you can cause another kind of addictive behavior. For cocaine treatment, one needs a short-term therapeutic community with ongoing, long-term follow-up with these individuals. Some of the common personality factors associated with addicts include problems of self-esteem and conflicting parental values. As an aside, if you have a mother or father who is an alcoholic, or you are male whose father is an alcoholic, you have a 50 to 75 percent chance of becoming an alcoholic. This would suggest that people who have a parental background of alcoholism should stay away from alcohol altogether.

There are three different kinds of drug users. Experimental users may try various drugs once or twice out of curiosity and then leave them alone and go on about their business. A study of high school seniors in this country has shown that marijuana use really peaks at age 18. The study, though, had a great many weaknesses, especially since it did not adequately address drug use among dropouts. The states have to insist that the National Institute of Drug Abuse, which funds such studies, begin to look at dropouts because they have a 67 percent greater chance of being involved in substances than their cohort group of seniors in high school.

Another kind of user is the recreational drug user. This is where drugs are taken to get high with friends at a party, and that is generally where things really start. These persons get used to a crack high, they long for it, and they can't do without it.

The third kind is the regular drug user and the dependent user. They go on from the use of gateway drugs -- liquor, cigarettes, and marijuana are considered gateway drugs -- to harder, more addictive drugs.

There are a number of phases of drug abuse. In the first phase, the gains outweigh the losses. It is very difficult to get people into treatment when they are in this phase of drug abuse. The second phase is where gains and losses are equal. We sometimes get people into treatment from this phase who are generally forced into treatment by families or the court if they have a problem with the law and are sentenced to a drug treatment program. But in the third phase, we get a lot of people where the losses clearly outweigh the gains of taking drugs for many years.

What we need in this country and in every state is a social model of prevention. The community needs to establish rules regarding chemical use -- when you can use these drugs; where you can use them; when it is legitimate to use them; is it necessary to use them; what behavior should be tolerated by individuals who do use chemicals; what behavior should not be tolerated? We also need to establish a way to communicate these particular "rules" to the rest of the community so they will know not to violate them, through the media, through schools, through churches, through the family.

If we are going to be effective in trying to have a drug-free America, we first are going to have to not glamorize or advertise the use of alcohol and certainly cigarettes. As an aside, the leading cancer now among black women in this country is lung cancer. It now surpasses both uterine and breast cancer as the leading cause of death.

Has the community established a system of accountability? In other words, through care, love, and concern, through family, friends, employers, schools, and the courts, have we decided what's okay in terms of behavior, in terms of chemical use, and decided what's not okay? And if somebody gets in the "what's not okay" area, have we decided to get them back into the what's okay area so that they can function in society and become taxpayers? It's really important that this occurs with all the

fervor that we can garner. We can do it through Alcoholics Anonymous; we can do it through Narcotics Anonymous; we can do it through MADD and SADD and all those acronyms that have been established. We must encourage social competency, where individuals themselves have clear values that have been communicated to them by parents and teachers and police and the courts and everybody else responsible for behavior. We must have emotional coping skills so that persons can learn to deal with stress, and when they have a stressful problem, they know avenues to use to get over that problem. Also important are good decision-making skills, communication skills, and certainly alternative highs. We also have to teach people how to be high off life or high off their productivity. This is really, really important.

One other point that is terribly important and is associated with the problem of substance abuse is AIDS. In this country, as of January 19, 1987, 29,536 people had come down with AIDS, including 422 pediatric cases. That's tremendous. About 25 percent of those cases were from intravenous drug abusers, or the sexual partners of intravenous drug users. As a consequence, we are seeing transmission from intravenous drug users to heterosexual society. You don't have to be gay, nor do you have to be an intravenous drug user, to indeed come down with AIDS. In New York City, it was reported that one in every ten citizens now are positive for the antibody to the virus of AIDS. It also means that those people who are positive for the antibody are infectious. They are without symptoms, and if they have sexual intimacies with a person of either sex, they could pass on the virus and that person too will become positive for the virus. Twenty-five to 50 percent of those people who have the positive antibody will go on to get the disease. Twenty-five to 50 percent – that is a startling number. We now feel that in New York City, there are about 250,000 to 500,000 people who are positive for the antibody to the virus. In certain Central African countries, i.e., the Central African Republic, Zaire, Rwanda, Uganda, as much as 5 to 10 percent of the population is already positive for the virus. And they don't practice homosexual sex; the sex distribution ratio is one to one, women to men. It has been reported that by 1991, at least in that part of the world, approximately 5 million to 10 million people may die from AIDS. We have to worry about that in this country, and not one state has been spared. There's a whole lot of denial going on because people say that AIDS is a disease of homosexuals and that it is a disease of intravenous drug users. We're going to see a great deal more of this problem and the issue must be addressed.

One thing that is cause for concern, particularly for minorities in all of the major cities, is the heterosexual cases of AIDS. Among whites in the country, only 1 percent of diagnosed cases have been within heterosexuals. Among blacks, it is 12 percent. Among Hispanics, it is 3 percent of the cases. It is important to look at this because probably what is happening is we have a lot of in-the-closet gay or bisexual men, and we have a lot of in-the-closet intravenous drug users, where it takes a year or longer to find out that one's sexual partner is using drugs or having a homosexual relationship.

We have to come out in the open with this problem. The biggest killer of males between 20 and 49 in New York City is, indeed, AIDS. There is a disproportionate representation of races. Ethnically, blacks make up 12 percent of the population in this country, and 25 percent of AIDS victims; and Hispanics are about 8 percent, but make up 14 percent of that AIDs victims. And this is because these minorities are disproportionately represented in the intravenous drug-using categories.

The federal government has passed a law to give more money for drug treatment, although it's been cut back somewhat. There is a "Catch-22," though, regarding funding for drug abuse. If we had more money in New York City, we couldn't open more treatment programs because the people who live in the communities wouldn't allow us. They don't want more expansion of treatment programs, even though the problem is expanding greatly. If we could get over the resistance of communities, then we could be able to do something about the problem of drug abuse in New York.

H. Leonard Boche, Executive Director, Minnesota Association of Treatment Programs

The states have faithfully been the custodians of public policy, which has taken the long-term view of alcohol and drug abuse problems while the federal government has declared intermittent all-out war and armistice depending on the election calendar and/or the state of public panic that may exist at any one time. The states are to be commended for their resolve and stability in the long-term struggle to find effective responses to the alcohol and drug abuse problem.

A Comprehensive Viewpoint

It is necessary to adopt a comprehensive view in which the distinctions made between alcohol and other psycho-active substances are seen as minimal. A generic approach is more consistent with the experience of the patients we see. There is no nationally accepted language for this viewpoint so we stumble about by using phrases like "substance abuse" or "chemical dependency" while the federal government maintains separate institutes and provides no leadership for a comprehensive approach. Again, it is the states that have been the innovators and have provided the "big view." If this task force could help develop a national language for the generic approach to alcohol and drug problems, it would be a historic achievement. During appropriation season there is a strong temptation to pit prevention against treatment as if these two elements are antithetical. That view is rejected here, for prevention and treatment are inseparably part of the same cloth. In the history of civilization's efforts to deal with public health threats, it is found that treatment for the disease often is found before means of prevention are discovered. It is not unusual for the means of prevention to be learned from the experience and insights of treating the victims.

Commitment to treating the casualties of substance abuse gives credibility to prevention efforts. In Minnesota, the credibility of school prevention programs soared when school districts established employee assistance programs for administrative staff and faculty. Kids respond to consistency and are quick to pick up on hypocrisy. Sound prevention programs are built on the foundation of a humane attitude that includes treatment of those who become dependent and addicted.

There are two cliches that are continually being reinforced as more data becomes available -- namely, treatment doesn't cost, it pays, and you can pay me now or you can pay me later.

The work of Holder and Hallen in the longitudinal study of Blue Cross subscribers in northern California found that treatment of alcoholism resulted in significant reductions in utilization and cost of all health care -- not only for the alcoholic, but for the non-alcoholic family members as well. Treatment of alcoholism was not just humanitarian, but it reduced the health care costs of alcoholics and their families to the point of being less than the control group. The treatment of alcoholic people didn't cost, it paid. (Harold Holder and Jerome B. Hallen, H-2 Inc., 211 N. Columbia Street, Chapel Hill, N.C. 27514) Similar findings are reported by Gary Graham, M.D., medical director for Kemper Insurance Group, Chicago, Illinois.

The 1985 report of the Chemical Abuse/Addiction Treatment Outcome Registry (CATOR) prepared by the Medical Education and Research Foundation of the St. Paul-Ramsey Medical Center reported on the six and twelve-month follow-up of nearly 3,000 persons treated for chemical dependency. That report summarized their findings by stating, "In addition to the obvious benefits to individual patients and their families, treatment programs appear to offer significant economic rewards to local, state, and federal governments, as well as insurance providers and private industry." (Norman G. Hoffmann, CATOR, 640 Jackson Street, St. Paul, Minnesota 55101)

The CATOR study further points out that society incurs substantial costs for persons who are actively chemically dependent and that the drain of resources is curtailed when intervention occurs and society invests in treatment.

A Continuum of Care

An effective treatment system is based on the understanding that recovery is a two-year process in which the patient will use a variety of services with varying degrees of intensity. There is no quick fix nor is there one miracle methodology that is so superior as to exclude consideration of others. The programs that closely tie together formal treatment with self-help aftercare seem to be most effective in helping people to recover.

The resulting continuum of care will have within it four functions: case finding and intervention services; emergency services and detoxification; primary treatment; and aftercare.

Case Finding/Intervention Services. A broad range of community "gate keepers" often are the people turned to in times of crises. Gate keepers who are sensitive to and knowledgeable about substance abuse are often key actors in getting families and dependent people in touch with the appropriate treatment resources. Formal intervention services are often crucial in helping the person to accept help. Employee assistance programs have proved to be cost-effective for both public and private employers. Rarely do people come for help "voluntarily," but rather accept help as the result of a crisis. The task of intervention services is to channel the energy of a crisis into constructive outcomes. This task becomes easier when the social stigma is reduced and there is a cultural understanding that chemical dependency is a treatable condition.

Emergency Services/Detoxification. Toxicity resulting from an overdose of alcohol or other drugs can be a life-threatening condition. The first task of a detoxification program is safety. It has been found that specialized services for intoxicated persons serve their needs more efficiently than do general purpose emergency services. The key to the management of the intoxicated person is easy access to the service. The admission process must be quick and sure, operating under standing orders that take into account the needs of the intoxicated person and administered by people who have the ability to relate to the presenting person in a nonjudgmental manner. General purpose emergency services tend not to meet these conditions.

Another major function of detoxification is to help the person to accept help and to refer the person to appropriate services.

Primary Treatment. Primary treatment is that set of learning and therapeutic activities following detoxification where the patient is introduced to his or her illness and given the tools to stay sober. Two of the ingredients are hope and a discipline of recovery. The goal of primary treatment is to prepare the person to effectively use an aftercare program. The one factor that most clearly predicts success in treatment is the patient's willingness and ability to use the aftercare services.

Primary treatment can be hospital-based, freestanding, residential, or outpatient. The level of environmental control required for a particular patient is a hotly debated issue at this time. The historic models relied very heavily on residential treatment, which was effective and economical. Because health insurance providers would pay for treatment only if it were in a medical facility, treatment moved into higher-cost settings in order to get payment for services. Now health care planners are telling the field that residential chemical dependency treatment is too expensive and that treatment has to be delivered on an outpatient basis. It must be pointed out that inpatient chemical dependency treatment became expensive as the result of the health insurance industry's insistence that treatment be more medical as a precondition for payment. The patient cannot be permitted to be a pawn in this debate, but must be provided quality care, whether residential or outpatient.

Aftercare. Aftercare is crucial to success in treatment, for it provides the framework for the learning started in primary treatment to be internalized. For some patients more formal therapeutic aftercare is indicated, while other patients will do well with self-help groups such as Alcoholics Anonymous or Narcotics Anonymous.

Some patients will not have a home to return to, or, in some cases, the family will be so injured that return to them would be ill-advised. These persons will benefit from residential aftercare or a halfway house. Some patients need more time in a structured supportive setting in order to break the pattern of chemical dependency and start life anew. The halfway house helps the person use community resources appropriately and provides for the orderly reentry into the community.

Problem Solving

People who suffer from substance abuse develop lifestyles that are filled with problems, i.e., job, family, court, financial, etc. The temptation is to look at these problems as the cause of the substance abuse, when in fact, these problems may be the result of the illness. Major assistance in problem solving needs to be made available to patients after they have established basic patterns of sobriety. Problem-solving help given to actively using chemically dependent persons usually is misapplied.

Basic Understanding of Alcoholism and Drug Abuse

Clinical observations, more recently supported by additional research, recognize that chemical dependency is disproportionately found in certain family lines, as is true with diabetes. There is new appreciation for the presence of a genetic component in the development of alcoholism. The old adage that some people are born alcoholics seems to have a basis in fact.

We live in a drinking culture and that, coupled with the presence of prescribed and recreational drugs, means that there is nearly universal exposure to psychoactive substances in the American culture. This nearly universal exposure, placed against a substantial genetic pool of persons disposed toward uncontrolled use of such substances, results in a disease phenomenon.

Over the past 40 years, we have learned that the condition is treatable, that people do recover and return to full productive lives, and that treatment doesn't cost, but rather it pays! Treatment also creates the hope upon which prevention efforts can be built.

David L. Armstrong, Attorney General, Commonwealth of Kentucky

The crime of drug abuse is a crime that arouses great passion and emotion. But it is also an economic crime, a crime of supply and demand. There are many ideas that relate to education and prevention, as well as early intervention and treatment. These ideas are aimed at cutting off the "demand" for drugs. But to complete the program, we also must work to cut off the "supply." Staggering profits are the incentive for drug trafficking, and to eliminate the problem, we must eliminate the profit. To confront and defeat alcohol and drug abuse, we need a multifaceted approach to a complicated problem.

The following recommendations are based on years of discussions with law enforcement professionals:

Law Enforcement Education. Law enforcement officers should be educated on alcohol abuse. Through education, we can recondition law enforcement officers to deal more effectively with drug and alcohol abuse. Presently, the training is inadequate. For example, in Kentucky, 400 hours of training are required for law enforcement officers. Out of that 400 hours, only four hours are dedicated to substance abuse. We need to provide law enforcement officers with more adequate training as to drug and alcohol abuse, and to provide updated training and information on a regular basis so that they can be fully prepared to play an effective role in confronting alcohol and drug abuse.

Judicial Training. Training on drug and alcohol abuse should be provided to prosecuting attorneys and judges. This training, which could involve the attorney general's office in cooperation with the state agency responsible for substance abuse programs, could be conducted on

an annual basis for local prosecutors and judges specific to identification, prevention, and early intervention strategies. Also, information on diversion programs for offenders charged with drug and alcohol abuse would be helpful to the local prosecutors and judges. The rationale for this type of training would be that in an effort to identify, intervene, and direct the drug and/or alcohol offender toward appropriate treatment, the attorneys, prosecutors, probation and parole officers, and judges need to be more aware and up-to-date on drug and alcohol programs and strategies.

Dram Shop Laws. States should be encouraged to enact dram shop law. This would be designed to reduce the serious injuries and deaths resulting from drunken driving by encouraging retailers of alcohol to act responsibly in the conduct of their business. Incentives within the model act could potentially encourage licensees not to serve minors and to intervene with problem drinkers so that they do not become intoxicated and operate a motor vehicle. The Dram Shop Act also could serve as a means to compensate innocent victims of drunken drivers. In many cases, innocent victims have no recourse against intoxicated drivers because the driver may be "judgment-proof." The Dram Shop Act would place the burden of compensation upon licensees who have acted irresponsibly with knowledge that their actions directly endangered others. A "responsible business practice defense" could be included to protect establishments against unfair lawsuits.

Elementary Education. Law enforcement officers responsible for drug law enforcement could be utilized to make presentations to fifth and sixth grade students as to the legal consequences of drug experimentation. It would seem important to reach the students at the elementary school age, prior to the time when many of the students begin experimentation.

Drug and Alcohol Law Review. Laws proscribing the use of alcohol and drugs should be reviewed for their adequacy. The sanctions prescribed by these laws may be adequate, but the enforcement of these laws and imposition of the prescribed sanction may provide room for improvement. It seems that too few drug offenders go to prison. Too few drug offenders are required to attend drug treatment programs as a condition of probation.

To get tough on drug offenders, we need a unified approach. Police officers, prosecutors, and judges need to work together to make examples of some of the more serious drug traffickers. Usually, it is the street dealers, who are junkies themselves, who get busted. The big drug dealers who are higher up the chain of distribution rarely get caught.

Law Enforcement Cooperation

Greater cooperative law enforcement efforts are needed among local, state, and federal law enforcement officials. There needs to be regular meeting and exchange of information as to specific cases and drug offenders, who are often on the move among jurisdictions. By comparing notes, law enforcement agencies can help each other and bolster their cases. The suggested cooperative law enforcement efforts to exchange information should be on the regional as well as statewide level. Sometimes we hear of problems with turf battles and lack of trust between law enforcement agencies. As a result, this regular cooperative exchange of information and meetings should be strongly encouraged in each state so that we deal with the real enemy – the drug trafficker.

Realigning Priorities

Police administrators need to consider realigning priorities to use a greater amount of their limited resources for drug law enforcement so as to create a long-term effect. Of course, given the competing law enforcement interests that each police administrator must confront, the basic need here is additional funds to effectively provide drug law enforcement.

Asset Forfeiture Statutes

Better use of the asset forfeiture statutes is needed at both the state and local law enforcement levels. These statutes can permit confiscation of property used to further the crime, as well as the

"fruits" of the crime. Examples would be confiscation of vehicles, property, bank accounts, drug money, etc. Under forfeiture statutes, confiscation of these kinds of drug assets go to the law enforcement agency responsible for the enforcement of the drug laws against the particular offender.

Enforcement of forfeiture statutes is very important to take the profit out of crime. Also, it provides one source of additional funding for drug law enforcement.

There is also a federal forfeiture statute. If the cooperation among federal, state, and local drug law enforcement agencies can be encouraged, this can be a strong tool in the effort to take the profit out of drug crime.

Targeting Law Enforcement Resources

The law enforcement effort to more effectively reduce the supply of illegal drugs will not be without its costs. State and local governments need more money to devote to drug law enforcement. Specific needs include the following:

- More manpower. For example, there are no more than sixty law enforcement officers in Kentucky who work full time on drug law enforcement.

- More money. Funding is needed to coordinate various law enforcement agencies to encourage cooperation, information sharing, and the compilation of information and regular dissemination of this information to the local law enforcement agencies. The coordinating agency should go around the state and conduct regional meetings with local law enforcement personnel to provide a forum for this cooperative effort.

- Equipment. More and newer equipment is needed, such as law enforcement vehicles that are not readily identified as such, radios, and surveillance equipment.

- Drug-Buy Money. This is needed to entice the offender, especially to get the large drug traffickers, who usually deal in large sums of money. Larger drug-buy funds are needed to entice the larger offenders.

- Drug law enforcement personnel rely upon informants. Informants do not talk for free, and often it is necessary to provide them money. Therefore, to make greater use of informants, greater sources of informant compensation are needed.

Beverage Penalties. Alcohol Beverage Control administrators should render severe penalties to licensees' repeated convictions for the sale of alcohol beverages to minors.

Undercover Programs. The development and coordination of programs for the exchange of undercover police officers between local jurisdictions for major investigations should be encouraged.

Prescription Drug Controls. Strong prescription drug laws should be enacted to discourage the illegal use of prescription and designer drugs.

Law enforcement has made a beginning. Most state police departments have an effective investigative team. Local police agencies also in many cases have developed units to concentrate on the investigation of drug trafficking. But the problem has grown faster than the solution.

Drug abuse and drug enforcement are local problems that need to be solved locally. To solve them, both federal and state financial assistance is needed. But that money is needed on the local level, as this is where the problems are and where they can most quickly be identified and confronted.

Today, there are some good examples of the team approach to this problem. The solution is not an easy one. It takes commitment by many different people with many different ideas and skills. It takes the commitment and solid prevention and education programs. It takes the commitment of law enforcement to work together. It takes the commitment of solid intervention and treatment programs. It takes the commitment of expanded funding. We can all work together to reduce the supply of illegal drugs, take the profit out of drug crime, and ultimately win the battle against drug abuse.

Alex Brodrick, Executive Director, Volunteers of America, Louisville/Lexington, Kentucky

For too many years, drugs and alcohol have shattered lives, destroyed families, and ruined the hopes and dreams of many in our country. In particular, alcoholism among the poor should be cause for great concern. Those who have few or no advocates and those for who are all too easy to overlook have felt the consequences of the failure to have treatment. It is the poor who feel the critical blunt of disappearing resources and unattentive governments.

Only a few short years ago, approximately ten, the problems of alcoholism among the homeless and poor were treated in Kentucky and other states of the nation through a network of programs commonly known as state hospitals, detoxification centers, halfway houses, and residential treatment centers. In each of the programs, treatment of alcoholism was available to all, and even the poorest American could detoxify and find a rehabilitation center in which to continue his life-threatening struggle for sobriety. While there were people on the streets, their numbers were lower and each of them had the opportunity to receive help for their alcohol problems.

Today, most of those opportunities are gone. Our federal government has focused on deinstitutionalization from state hospitals and put literally thousands of people on the street with no place to go. The government has also decided that the judicious expenditure of federal dollars does not include treatment services to the poor alcoholic, especially any type of intermediate or long-term assistance in institutions or halfway houses. Unfortunately, many states followed suit and quickly a fully developed network of detoxification programs, halfway houses, and institutions faded from the scene. These were replaced by mandated health insurance for alcohol treatment, increased outpatient alcohol services at comprehensive care centers, high-cost medical alcohol treatment centers, and sophisticated attempts at prevention aimed at educating America about the pitfalls of alcohol abuse. All these programs worked to some degree and continue working today, but none of them took into account the poor or nearly poor person with an alcohol problem. With the changes, those with money found increased opportunities for care and those without found "the street" and no relief from the bottle. They became the disenfranchized poor.

More than 50 percent of the people on the street in our cities are suffering from alcoholism, and an even larger percentage have serious alcohol problems. The population of those on the street has increased dramatically in the last ten years. Our prison system and county jails are jammed beyond capacity, and an increasing majority of the admissions to jails are for alcohol-related offenses. The cost of jails increases as do services to street people, and more and more street people die daily in dumpsters of heart failure, of liver disease, and of alcoholism. A serious look must be given to alcoholism among the poor, for they are disenfranchised and have no strong lobby for their needs.

My recommendations include the following:

- First, that the National Governors' Association choose to challenge government and their allocation of resources;

- Second, that the National Governors' Association take the unpopular position of proposing the redevelopment of alcohol services to the poor;

- Third, that the National Governors' Association consider the needs of those who are poor when looking at recommendations for education, intervention treatment, and law enforcement; and

- Fourth, the National Governors' Association take the lead in advocating for the poor in the critical area of alcohol and substance abuse. If the lead is not taken by NGA, it may not be taken at all, and the problems surrounding alcoholism, the poor, and the streets will continue to take its tragic toll on the lives of our fellow Americans.

Judge Andy Devine, Juvenile Judge, Lucas County Juvenile Court, Toledo, Ohio

Let us keep in mind Governors taking a lead role. A Governor has considerable power and influence in the Legislature and over the various departments and the leadership of those departments. If Governors have an understanding of the substance abuse problem, they can make a very, very significant contribution toward turning this problem around.

Parents, too, must take a lead role. They are the most important ingredient, the most important component of prevention of risk behaviors. Parents are the hub of the wheel.

Community commitment, too, is critical. They are the spokes of the wheel and include schools, mental health institutions, churches, the police, the courts, and everybody else supporting parents, understanding the role of parents, and helping them in this awesome task of rearing their children. These "spokes" should not raise their children for them, but with them, and should hold them accountable for their parenthood.

The juvenile court system can be used to mobilize parental accountability. If, for example, a child is consistently truant and benign efforts to get that child back in school have failed, a brief stay by the parent in the county jail typically will turn this situation around. We must say to parents, "it's your job, not our job, nor the teacher's job, to get that kid in school every day on time."

In addition to establishing and assuring parental accountability and fostering and nurturing a sense of community commitment, we must not wear out or burn out. It will take a lot of time and bear a lot of heartache to change a risk behavior such as substance abuse. But, we've got to hang in there if we are ever going to change it.

PART TWO: Alcohol and Drug Abuse Prevention: From Knowledge to Action

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FORWARD

The concern over the nation's alcohol and other drug problems has reached every segment of society. As a result of this national concern, the Anti-Drug Abuse Act of 1986 was signed into law (P.L. 99-570), creating the Office for Substance Abuse Prevention (OSAP). This office directs the federal effort in the prevention field by increasing knowledge about and promoting effective strategies to deal with alcohol and drug problems.

In carrying out this responsibility, OSAP is pleased to have an opportunity to provide assistance to the states through this collaborative effort with the National Governors' Association.

The success of prevention strategies will depend on the active and continuous involvement of entire communities, using many support systems. Prevention cannot be accomplished solely within the confines of a single organization. To elaborate, a support system within a community consists of parents; youth; and federal, states and local governments working through schools, law enforcement, human service, and health agencies. Other essential elements include sports and entertainment personalities, media and print specialists, business and industry, and volunteer organizations.

The models summarized in this document can simultaneously guide new efforts and provide a framework for analyzing common and diverse experiences. The guidelines represent the consensus of OSAP prevention strategies based on knowledge and evaluation of prevention efforts to date. Like the theories and models that have contributed to formulations of the guidelines, I expect, these principles will be expanded and refined in the future, based on the findings of new prevention efforts.

As you read through this document, please be aware that evaluation efforts of existing and new prevention models and strategies are underway. Problems can develop when untrained personnel use untested and/or inappropriate materials. Such problems can be avoided by working with community members to gather, organize, and review the problems in your state and communities before adopting a prevention strategy.

OSAP will be updating this information as more evaluation is completed and will be expanding the paper to include examples for booklets and other materials designed to promote drug-free communities. We look forward to working with you toward this important goal.

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INTRODUCTION

This paper was developed by the Alcohol, Drug Abuse, and Mental Health Administration's Office for Substance Abuse Prevention (OSAP) to serve as a reference point for planning strategies to combat alcohol and other drug problems in our states and communities. Following an "Overview of Alcohol and Drug Problems" in our society, the "Background" of comprehensive prevention strategies is elaborated.

"Theories and Models for Current Prevention Approaches" sets forth the rational bases from which today's prevention strategies are derived. Because prevention is an evolutionary field that is continually growing from the thinking and experiences of its planners and practitioners, the current body of knowledge may be expected to expand even as it is applied in our states and communities. The models summarized in this document can simultaneously guide new efforts and provide a framework for analyzing common and diverse experiences.

Finally, this paper suggests specific "Guidelines" for planning strategies to prevent alcohol and other drug problems. These guidelines represent the consensus of OSAP prevention strategists based on their knowledge and evaluation of prevention efforts to date. Like the theories and models that have contributed to formulation of the guidelines, the guidelines themselves may be anticipated to be expanded and refined according to the experience of the new prevention efforts.

OVERVIEW OF ALCOHOL AND DRUG PROBLEMS

According to a recent epidemiological assessment, deaths resulting from substance addiction account for an annual loss of more than 300,000 lives due to smoking; 100,000 lives due to alcohol consumption; and 30,000 lives due to use of other drugs. Alcohol and drug problems may be associated with acute use (e.g., automobile accidents), chronic use (e.g., liver cirrhosis), or a behavioral pattern of chronic use known as dependency. In the past decade, a greater number of teenagers have used alcohol and a variety of psychoactive drugs, and first use of these substances has occurred at increasingly younger ages. Tobacco, alcohol, and marijuana are seen as "gateway" drugs to later use of and greater involvement with a variety of substances that may lead to chemical dependency.

The estimated annual cost to our society of alcohol and other drug problems (excluding tobacco) is approximately $205 billion, of which $140 billion is attributed to alcohol abuse and $65 billion to abuse of other drugs. This represents approximately $850 per person in the United States and includes costs for lost productivity, crimes, accidents, fires, treatment, and various indirect expenses. This dollar estimate cannot begin to measure the personal and emotional suffering experienced not only by the abuser, but also by family, friends, employers, and coworkers.

The lifetime cost of a single alcohol and drug abuser currently is estimated at $85,000 in lost productivity and direct economic burdens on society; hence, prevention of drug abuse problems in even one youth can have sizable economic returns. The lifetime cost of a single case of Fetal Alcohol Syndrome is estimated at $596,000. Included in this estimate are expenditures for health and education, together with losses in market and household productivity. Large economic benefits from successful prevention efforts, therefore, can be realized.

OSAP has determined that the greatest savings by far can be realized by targeting youth and those who influence their knowledge, attitudes, and behaviors. Research has demonstrated that:

- Alcohol and other drug-using attitudes are formed during pre- and early adolescence.
- Almost no use of cigarettes, alcohol, or illicit drugs (except cocaine and abused prescription drugs) is initiated after age 25.
- Life expectancy has increased for every age group in the U.S. except 16- to 24-year-olds.

For these reasons, this paper emphasizes strategies that are designed to prevent the use of alcohol and other drugs by America's youth.

BACKGROUND

Over the years, researchers have identified multiple causes of alcohol and other drug-related problems. Genetic, behavioral, personality, environmental, cultural, and economic variables at one time or another have been examined independently as contributors to drug and alcohol abuse problems. More recently, these variables have been viewed as interwoven components of a complex pattern that requires comprehensive approaches. Accordingly, new emphasis is directed to examining the personal and social characteristics of individuals, families, and groups in relation to such societal or contextual factors as business structures and community "norms," standards, and expectations. The result is the evolution of integrated prevention approaches that are, at the same time, broad in scope and specific in their sensitivity to individual and cultural attributes.

Comprehensive and integrated prevention approaches are strongly recommended to develop awareness and educational programs, to reinforce social and legal policies, and to promote social and organizational structures that foster healthy, safe, and meaningful lifestyles. Such approaches emphasize a shared responsibility for addressing alcohol and other drug abuse problems and the need for long-term planning as well as for short-term crisis intervention. By definition, comprehensive approaches acknowledge that individuals function within broad social and physical environments and may be expected to respond differently to different interventions into their alcohol and drug use patterns. For example, it is already well documented that:

- License revocation is a more successful intervention than educational efforts for intoxicated drivers.
- Increasing the price of alcohol has an impact on youth as well as on adults and on heavy drinkers as well as on social drinkers.
- Raising the minimum drinking age is effective in reducing alcohol-related traffic fatalities among youth.
- Laws providing sanctions for intoxicated drivers must be accompanied by extensive awareness programs and enforcement efforts to be effective.
- School-based programs are receiving mixed reviews in the literature, with some speculation that delayed onset and decreased use result from activities that allow students to more correctly assess their peers' attitudes toward smoking, drinking, and other drug-use and allow a social norm of non-use to develop and be reinforced.

Comprehensive approaches also take into account the learning environments of individuals. Television, for example, has become a familiar fixture in the home. Health promotion and

employee assistance programs are multiplying at our worksites. Schools and families appear to be assuming increasing responsibility for health and social learning opportunities.

In short, for the times in which we live, to address a problem that affects every level of individual and societal functioning, only approaches that work at every level can be expected to yield positive results. Theories and models that work to support the development of comprehensive approaches are presented in the following section.

THEORIES AND MODELS SUPPORTING CURRENT PREVENTION APPROACHES

Models are derived from a body of research and allow us to generalize from one set of circumstances to the next. The models and theories presented here derive from a base of knowledge that, although usually associated with one or several researchers, has been expanded upon by numerous other researchers and practitioners. The models and theories selected for inclusion in this document appear to capture the latest thinking of the prevention field and should prove useful both for developing prevention programs and for assessing prevention approaches and products currently in the marketplace. Suggested guidelines developed by the Office for Substance Abuse Prevention follow the presentation of these models.

Learning Models

Social Learning Theory and Modeling (Bandura)

Albert Bandura's "Social Learning Theory" builds on the work of B.F. Skinner, who originally described the process of learning as a response to rewards and punishments. According to Bandura's theory, learning is acquired and shaped by the positive and negative reinforcements resulting from one's own behavior, as well as by observation of other people's behavior and its consequences for them. Bandura also notes that the ability to anticipate both the consequences of one's behavior and the attitudes of other persons toward such behavior develops as an individual matures. This ability allows persons to self-regulate or internalize rewards and punishments and to serve as agents of their own behavioral change.

Bandura recognized the potential for using "modeling" as a way of directing and changing behavior. We observe the behavior of others in person, on television, and by means of other communications media. The more attractive and competent a model is, the more likely others are to adopt that model's behavior. "Near peers," who are slightly older than the target audience and who resemble the target audience, often are used in educational programs to transmit messages by depicting behavior and attitudes that young people would like to imitate.

Cognitive Inoculation, Behavioral Commitment, and Cognitive Dissonance (McGuire)

William McGuire has outlined procedures for developing and maintaining attitudes, values, and beliefs that favor non-use of unhealthy substances. These procedures are called "pretreatments" because they are applied before a behavior is adopted or experimented with and are not designed for youth already using alcohol and other drugs.

"Cognitive Inoculation" is one of these pretreatments. Cognitive inoculation prescribes that lessons concerning attitudes and beliefs about alcohol and other drugs be accompanied by a discussion of the conflicting attitudes and beliefs that a student might encounter in the future. This teaching method prepares students for, and thereby protects them from, pressure to adopt beliefs and attitudes that may be unhealthy.

Another pretreatment approach requires that a "behavioral commitment" be made on the part of the individual. Commitments can take the form of a private decision, a public announcement of one's beliefs, active participation on the basis of the belief, and commitment based on awareness that someone else is committed to the belief (external commitment). McGuire was surprised to find that external commitment was stronger than a private commitment in most cases -- convincing evidence for the power of peer, parental, community, media, and societal support for non-use behavior among youth.

In addition, McGuire found that, in general, people want their attitudes and beliefs to be compatible with their behavior. If they are not, there is "cognitive dissonance" that a person will want to eliminate. For instance, if an adolescent strongly values his or her athletic ability, to successfully attach the belief that smoking marijuana diminishes this ability would create dissonance. Resolution of dissonance would require the individual either to abstain from smoking marijuana or to place a lower value on athletic ability. Connecting new beliefs about alcohol and other drugs to existing cognitions, if used as a pretreatment or prevention measure, requires a clear understanding of the cognitions students holds important.

Social Inoculation Theory (Evans)

Richard Evans' "Social Inoculation Theory" extends McGuire's theory to address the many social influences, beliefs, and attitudes that create pressure on a young person to use alcohol and other drugs. Such pressures might include, "If everyone is doing it, it can't be bad," or joining a group that, by its use behavior, exerts pressure on the young group member. Students are instructed about social pressures to use alcohol and drugs and are assisted with the development of skills to resist the pressures. Many programs based on the Social Inoculation Theory use modeling, as suggested by Bandura, to teach peer resistance skills. Others encourage public commitments from students as an added incentive to resist negative peer pressure and as positive social reinforcement for the group as a whole.

Behavioral Development Models

Development Model (Erickson)

Eric Erickson argues that psychological development occurs in identifiable stages throughout the life cycle. In order for one to develop a healthy personality, the psychosocial "crises" associated with each stage of development must be successfully resolved. In the first year of life, for example, a child must develop a sense of trust rather than mistrust. Similarly, autonomy (versus doubt) must be developed in early childhood (2-3 years of age); initiative in play (4-5 years of age); and, industry, during the elementary school years. Erickson argues that the major crisis to be dealt with in adolescence is that associated with establishing identity and avoiding identity diffusion.

Adolescence is a period of transition. Erickson calls it a period of role confusion out of which identity should emerge. The individual who has previously accepted his or her role as a child now attempts to adopt some aspects of the adult. Certain adult behaviors, such as being sexually active, smoking, and drinking alcohol, are considered deviant because they are essentially adult behaviors exhibited at an earlier stage of the life cycle.

A second aspect of role confusion involves the adolescent's developing self-image. The adolescent's body changes rapidly. The rapid physical change cause the young person to feel

clumsy and ill-at-ease. These physical and social changes often result in a poor self-image among adolescents and in excessive concern about acceptance by others, especially peers.

The identity crisis also is marked by changing relationships with parents. As adolescents break away from the previously close personal guidance of their parents or guardians, they seek support elsewhere, usually with a peer group. In this developmental context, smoking and using alcohol and other drugs may appear to the young person as a way of expressing a growing sense of independence.

Behavioral Intention Theory (Fishbein and Ajzen)

Martin Fishbein and Icek Ajzen have developed a system of quantifying attitudes because, like others, they believe that attitudes are logical determinants of behavior. Their theory states that, when measured properly, attitudes and subjective norms held by an individual can be used as predictors of behavioral intent and of behaviors. Attitudes are the beliefs a person holds about the outcome of a behavior along with the value he or she places on that outcome. Subjective norms are the individual's assumptions about the views of significant others regarding the behavior, along with the individual's motivation to comply with these views.

In order for attitudes and subjective norms to be good predictors of behavior, their measurement must be in terms of specific behavioral situations, e.g., a person drinks (action) beer (target) in a car (context) on the weekend (time). Attitudes and subjective norms must be assessed keeping the action, target, context, and time in clear focus. This measuring technique ensures that the content of messages used to change attitudes is relevant to the target group and that adequate attention is given to the strength of social influences on behavior. This theory provides a good framework for understanding the important role that perceived social norms play in directing behaviors. For example, adolescents generally perceive a prevalence of alcohol and drug use among their peers that far exceeds actual consumption. Students who overestimate the use of alcohol and other drugs may view use as "normal" and may be more accepting of such use.

Social Development Model (Hawkins)

David Hawkins and his colleagues have developed a "Social Development Model" that seeks to address key risk factors for alcohol and other drug use at developmentally appropriate points. Hawkins advocates providing a young person with opportunities for active involvement, skills for successful participation, and a consistent system of rewards and punishments. According to the Social Development Model, this practice will lead to the development of bonds of attachment, commitment, and belief between young persons and the social units (families, school classrooms, or groups of friends) in which they participate. The model also suggests that when a social unit's expectations or norms for behavior are clear, young people will be less likely to violate these expectations, particularly if they feel socially bonded to the unit.

According to the Social Development Model, prevention programs should seek to increase opportunities for active involvement in family, school, and positive peer groups; ensure the development of skills needed to perform successfully in childhood and adolescence; and ensure that children's social environments provide clear expectations and consistent reinforcement for behavior.

Health Behavior Theory (Jessor and Perry)

The formulation of Richard Jessor and Cheryl Perry's "Health Behavior Theory" follows in the tradition of Karl Lewin's Field Theory, which emphasizes the unique developmental history each person brings to a situation and, at the same time, the similarities among people due to common circumstances.

Like Lewin, Jessor and Perry take great care to specify the variables and relationships among variables that influence behavior -- specifically, health behavior -- in order to address multiple

behaviors. Health is comprised of four domains: physical, psychological, social, and personal. Because a single behavior can affect several of these health domains, their relationship must be examined fully in terms of prevention strategies.

Jessor and Perry recommend two strategies for prevention: 1) weakening or eliminating behaviors that compromise health; and 2) strengthening or introducing behaviors that enhance health. These complementary strategies are the products of a prevention focus directed toward achieving a balance in an individual's entire behavioral functioning. Because a covariation exists among a number of health-compromising behaviors, i.e., adolescents engaged in one of several risky behaviors are more likely to be involved in others, preventing or eliminating any health-compromising behavior may have an effect on other behaviors. The promotion of health-enhancing behaviors includes the understanding that alcohol and other drug use may be serving as a way to gain independence from parents; with this understanding, new and healthier behaviors that serve the same purpose may be introduced.

Stages of Drug Involvement (Kandel)

Denise Kandel and her colleagues describe drug use as a process of clear-cut stages and largely determined by a matrix of social relationships. Different influences are involved at different stages, with situational and interpersonal factors most important for initiation into drug use behavior and psychological factors most important for increased involvement or participation in that behavior.

Three specific stages of drug use described by the researchers are: 1) use of liquor, 2) use of marijuana, and 3) use of other illicit drugs. Distinct predictors mark initiation into each stage of use. The most important predictor of liquor use is the involvement of a youth in minor delinquent activities. Young persons with beliefs and values favorable to marijuana use and also are associated with friends who use marijuana are more likely to enter the second stage of drug use. Parental factors, feelings of depression, and contact with drug-using peers are the primary predictors of illicit drug use.

Misuse as a Deviant Response (Kaplan, Martin, and Robbins)

Kaplan, Martin and Robbins' model is an explanation of deviant behavior that, inasmuch as drug use in adolescence is an example of deviance, provides one explanation for such use. The researchers note that deviant responses are motivated by the adolescents' earlier development of self-rejecting attitudes. These attitudes result from unhappy or unsatisfying normative participation in a variety of interpersonal or social interactions.

According to the researchers, repeated self-devaluing experiences in membership groups will take away personal motivation to conform with nominative patterns of behavior. When normative patterns of behavior are no longer motivationally accepted responses, deviant patterns represent alternative responses by which an individual can act effectively to boost self-esteem.

Drug use is more visible if it is prevalent among peers at school or in the neighborhood. An individual's perception of the likelihood of self-enhancing consequences resulting from a particular pattern of drug use also reflects such variables as perceived attitudes toward the pattern of drug use held by positive and negative reference groups; the visibility of more or less prevalent adverse consequences of use; the perceived compatibility of consequences and concomitants of the drug use pattern with behavior appropriate to valued social roles that are not themselves the basis for one's rejection; and the ability to justify use without experiencing overwhelming feelings of guilt.

Sensation-Seeking as an Explanation for Drug Use (Zuckerman)

Marvin Zuckerman's research has explored the relationship between an individual's need for sensory stimulation and a host of behaviors, among them the use of alcohol and other drugs. He

observes that all individuals look for varied, novel, and complex experiences, but have different optimal levels of arousal.

Stimulation serves different functions. Zuckerman found the primary functions to be: offering thrills or adventure; providing new experiences; facilitating disinhibition; and reducing boredom. Using alcohol or other drugs, eating, smoking cigarettes, and engaging in sexual activity are all sources of sensory stimulation arousal. Individuals who have strong sensation-seeking tendencies are more likely to engage in these activities and to a greater extent.

The most important demographic correlates with sensation seeking are age and sex. Thrill or adventure-seeking and disinhibition-seeking declines after age 30. Males generally score higher on all sensation-seeking scales except for experience-seeking. Zuckerman has found that persons who experiment with a variety of drugs tend to score high on the sensation-seeking scale. Alcohol use alone, however, tends to be associated with a narrower kind of sensation-seeking, that of the disinhibition type.

Communications Models

Health Promotion and the Knowledge-Attitude-Behavior Continuum (Bettinghaus)

Erwin Bettinghaus expands the original knowledge-attitude-behavior continuum by including research from Fishbein, McGuire, and others to suggest ways to improve health campaigns aimed at avoiding, maintaining, increasing, changing, or adopting new behavior. Evaluations of such campaigns have found that they are effective in gaining the attention and in arousing the interest of a target audience. Bettinghaus suggests that the knowledge-attitude-behavior model can be improved by using measures of behavioral intention (Fishbein) rather than generalized attitudes. In addition, Bettinghaus advocates addressing countermeasures (anti-smoking efforts that compete with pro-smoking print media messages); difficulty (losing fifty pounds is more difficult than reducing salt intake by 10 percent); addictive properties (of tobacco, alcohol, and other drugs); and social pressures (from peers). Finally, Bettinghaus proposes the use of McGuire's information processing model, which argues that moving between the elements of the knowledge-attitude-behavior continuous demands processing time on the part of individuals, as well as attention to a set of elements within a communication matrix. The matrix includes, at least, addressing attention, comprehension, yielding, retention, and action, while, at the same time, paying attention to the five elements of the communications process (source, message, channel, receiver, and destination).

Communication-Behavior Change Model (Maccoby and Solomon)

Nathan Maccoby and Douglas Solomon have studied mechanisms used by mass media campaigns to change behavior and have defined steps required to move a target population from initial awareness of interest in a problem to the adoption and maintenance of advocated attitudes or behavior. The first step involves attracting attention and focusing it on specific issues and problems, a process referred to by mass media researchers as "agenda setting," which, for major national campaigns, has been accomplished by broadcast media. Once a subject is on the public agenda and is perceived as an important issue, a campaign must explain the issue in a way that is personally relevant to individuals in the target audience; this step is referred to as "informing." The population also must be given positive incentives to change behavior, as well as support and encouragement to maintain new behavior ("motivation"). Once members of the population fully understand their personal relationship to the problem, they must be taught how to modify risk-related behaviors ("training"). Finally, if newly acquired habits are to be maintained, that maintenance must be accomplished by self-control ("self-maintenance"). Self-cuing at appropriate times and places is critical to the maintenance process.

Variables that exert an influence on each of these processes include the receiver's age, sex, socioeconomic status, current health beliefs, and previous education. Prevention strategies must be

designed to take into account the full range of potential influences operating at the personal, community, and economic levels.

Persuasion-Communications Model (McGuire)

William McGuire also has worked extensively on theory underlying communication campaigns. He describes the components necessary to construct a communication capable of changing attitudes and behavior, along with successive responses persons must make if they are to "yield" to the communication.

A communication is comprised of five variables: 1) source -- the characteristics of the individual from whom the message is perceived to be coming (which strongly influences the communication's credibility and acceptability to the audience); 2) message -- the context, how it is presented and organized, what is and is not included, and its length, speed of delivery, and other characteristics; 3) channel -- the medium through which the message is delivered, i.e., print, radio, or television; 4) receivers -- the target population; and 5) destination -- the type of behavior at which the communication is aimed.

According to McGuire, the effectiveness of a communication campaign depends on its ability to lead an audience through a successive twelve-step process:

1. Being exposed to the communication.
2. Attending to the communication.
3. Liking or becoming interested in the communication.
4. Comprehending the message.
5. Learning how to incorporate the target behavior in one's life.
6. Accepting or yielding to the change.
7. Remembering the content of the message and remembering that one has agreed to it.
8. Being able to retrieve the information from memory.
9. Making decisions based on the retrieval of the information.
10. Behaving in accord with the decision.
11. Experiencing reinforcement for the behavior.
12. Engaging in postbehavioral activities, such as reorganizing one's related beliefs.

Diffusion of Innovations (Rogers)

Prevention often entails the introduction of new health-related ideas to members of a social system. The process by which new ideas or products are spread is called "diffusion." Everett Rogers has studied the diffusion process and has observed processes that both facilitate and impede diffusion.

It is not critical that an idea or product be original in order for it to be considered innovative. Rather, it is the perceived or subjective newness of an idea to an individual that determines his or her reaction to it. New ideas can be introduced from within the social system or from outside. When introduced from outside, new ideas spread by selective contact change or through directed, planned change. Either way, the rate of adoption of a new idea is influenced by several factors, including: the degree to which the innovation is perceived as better than the idea it supersedes, i.e., its relative advantage; the degree to which an innovation is perceived to be consistent with the existing values, past experiences, and needs of the receiver, or its compatibility; the degree to which an innovation is perceived as difficult to understand and use, or its complexity; the ability to test the innovation before fully adopting it, or its trial ability; and the degree to which the results of the innovation are visible to others.

Rogers notes that, if the stage of introducing a new idea is at the awareness or information level, mass media channels are the most rapid and efficient mechanism. If, however, the stage is at the attitude, the behavior change, or the "adoption point," then an interpersonal, face-to-face

interchange is much more effective. The most successful diffusion occurs when mass media are used to build awareness and reinforce newly adopted attitudes and behavior in conjunction with face-to-face interchanges for trying, adopting, and maintaining new attitudes and behaviors.

Public Policy Models

Price Policies and Prevention

Other researchers are looking at the macroeconomic, environmental determinants of tobacco and alcohol consumption. For instance, two recent alcohol consumption studies, one by Cook and Tauchen and the other by Grossman, Coate, and Arluck, present the strongest evidence to date that consumption is responsive to changes in the price of liquor. Cook and Tauchen (1982) found that an increase in the liquor excise tax by a dollar per proof gallon reduces the cirrhosis mortality rate by 5.4 percent in the short run and by perhaps twice as much in the long run. (Liver cirrhosis rate provides a reliable measure for estimating chronic excess consumption.) This important finding addresses the skepticism that consumption by heavy drinkers, because it is habitual or addictive in nature, also is insensitive to increased taxation. Cook and Tauchen's findings suggest that, while heavy consumers of alcohol may adjust by purchasing less expensive brands, their overall rate of consumption also declines in response to increased taxes.

Grossman and his colleagues (1984) found results compatible with those of Cook and Trauchen and demonstrated that price sensitivity effects are particularly prevalent among young people. The researchers found that a ten-cent increase in the cost of a six-pack of beer, a thirty-cent increase in the cost of a fifth of liquor, and a one-year increase in the legal age for purchase of beer had approximately the same impact on consumption. Similarly, Cook's work shows the connection between even small increases in excise taxes on hard liquor and reductions in fatality rates to alcohol-impaired driving and cirrhosis.

Minimum Drinking Age

Research also indicates that lowering the minimum age for purchase of alcohol is associated with an increased rate of automobile crashes among young people. Conversely, increasing the minimum age of purchase reduces the rate of automobile crashes among young people.

Cook and Tauchen (1984) analyzed auto fatality rates for young people during the eight years between 1970 and 1977 in the forty-eight contiguous states, along with levels of availability of alcohol to young people in those states. They concluded that a reduction in the minimum legal drinking age from 21 to 18 years for all alcoholic beverages would increase the rate of auto fatalities for people between 18 and 20 years of age by about 7 percent and by somewhat less for 16- and 17-year-olds.

Coate and Grossman also examined the effects of minimum legal drinking ages on alcohol consumption by young people ages 16 to 21 and found that frequency of consumption of beer, the most popular alcoholic beverage among youth, is inversely related to the minimum legal age for its purchase and consumption. The researchers estimated that a uniform minimum drinking age of 21 for beer in all states would have reduced the number of youths who drank beer four to seven times a week during the sample period by 28 percent and the number who drank one to three times a week by 11 percent.

Other Restrictions on Availability

Research into the physical availability of alcoholic beverages and other drugs has resulted in varying findings but generally supports the hypothesis that a reduction in availability is correlated with lower use rates and incidence of related problems.

MOVING FORWARD: SUGGESTED PREVENTION GUIDELINES

Based on current research findings, the Office for Substance Abuse Prevention has developed the following guidelines for prevention planners. Taken together, the guidelines direct planners to the most important starting points for prevention efforts.

Target High-Risk Families

According to several researchers who have conducted longitudinal studies or reviewed state-of-the-art literature, youth raised in certain "family" environments are at high risk for becoming involved with use of alcohol and other drugs. Different environments appear to protect young people from involvement. High-risk factors include the following:

- families in which one or more adults are engaged in alcohol abuse or illegal drug use;
- families with permissive attitudes toward adolescent alcohol and drug use;
- families experiencing major stressors that can include separation or divorce, economic hardship, discrimination, or recent losses; and
- families who cannot adequately provide a protective environment for their children and adolescents.

These families may not have the ability to teach age-appropriate mental, physical, emotional, and social skills; the ability to foster positive communication patterns, self-efficiency, and family bonding; the ability to deal with stress and overcome feelings of powerlessness, helplessness, and meaninglessness; or the ability to foster and promote prosocial bonding with schools, non-using and low risk-taking peers, and religious organizations.

Families that appear to be better protected against engaging in health-compromising behaviors appear to have many of these characteristics in common:

- higher economic status;
- lack of parental alcoholism, criminality, and mental illness;
- children spaced at least two years apart;
- at least one involved adult caretaker (not necessarily a parent or guardian);

- closeness and warmth combined with consistent rules and discipline and clear roles and responsibilities;
- literate parents who value and encourage education and prosocial bonding at school; and
- families who have access to financial resources, e.g., through employment.

Parents who generally are cautious about drugs, do not engage their children in drug-taking behaviors, such as lighting cigarettes or opening beers, do not approve of alcohol or other drug use by youth, do not tolerate intoxication or illegal drug use by adults, do not use drugs to solve problems, and do not role-model high-risk alcohol or other drug- taking behaviors, create more protective environments for their offspring. A protective environment also is characterized by the nurturing factors listed above, such as closeness, involvement, and appropriate discipline.

While it appears that some young people may be influenced by peer pressure to engage in alcohol and other drug-taking behavior even though they do not want to, other research suggests that some young people may be predisposed to engage in health-compromising behaviors when peer pressure is exerted. One study, for instance, found that the greater one's willingness to conform to antisocial peer pressure, the stronger the association between perceived pressures and self-reported misconduct and antisocial behaviors. Other researchers have found that there are certain individuals who are more predisposed to become engaged in risk-taking behavior that, during adolescence, often is associated with alcohol and other drug use. These youths have been described as "sensation-seekers" and presumably have low thresholds for boredom and routine, as well as special needs.

According to the researchers, the act of engaging in excessive risk-taking behavior can help individuals assert personal control of their lives; express opposition to adult authority and conventional society; deal with anxiety, frustration, inadequacy, and failure; gain admission to a peer group and demonstrate identification with a youth subculture; confirm personal identity; affirm maturity; and mark a developmental transition into young adulthood.

Developmentally, risk-taking behavior serves an important function for adolescents. They are breaking away from the family to establish their independence and identity, to establish a support group outside of the family to which they want to "belong," and to establish "adult-like" behavior.

Many would suggest that modern society provides few alternative ways for youth to establish their identity and maturity. Many rites of passage, evident in earlier societies, no longer exist. Others would argue that those who engage in excessive risk-taking behaviors do so because of personality systems characterized by lower value on academic achievement, higher value on independence, greater social criticism and alienation, lower self-esteem, orientation to an external source of control, greater attitudinal tolerance of deviance, and lesser religiosity.

The researchers strongly suggest that there is a "psychosocial" readiness among some young people to engage in antisocial and excessive risk-taking behaviors. This does not mean that the adolescents are aiming for risk, but rather are choosing behaviors because of how the behaviors make them feel -- thrilled, socially adequate, or stimulated. Young people, themselves, do not perceive many of these behaviors as "risky" or "antisocial."

Start Prevention Early

Even though there have been few studies that focus on childhood and pre-adolescent predictors of alcohol and other drug use, we do know that the age of initial use has been declining. For instance, by age 13, 30 percent of boys and 22 percent of girls classify themselves as "drinkers." A 1987 *Weekly Reader* survey showed that peer pressure can begin as early as fourth grade. This report found that while pressure to use marijuana had decreased from what it was in 1983, the level of peer pressure had remained unchanged for alcohol -- ranging from 36 percent of students

experiencing such peer pressure in fourth grade to 51 percent in sixth grade and 76 percent in grades seven and twelve.

Children in kindergarten through sixth grade have been found to have greater expectations that they will use alcohol and other drugs if the adults in their families are users of illegal substances and cigarettes or abusers of alcohol and if these adults engage their children in "drug-taking behavior," which may include asking the children to light cigarettes, pour and serve alcoholic beverages, or get medicines. Another study of 133 families in New York found that parental characteristics measured during children's first three years could discriminate those children who later were using alcohol and other drugs at age 16 or older.

Many studies have found that early involvement by youth in alcohol and other drug use increases the likelihood of future problems with alcohol and other drugs. One researcher who has followed youth over a long period of time found that early use of alcohol, for instance, represents a "watershed" crossed in relation to later involvement in a wide range of problematic behaviors. Others have found that those who exhibit antisocial behavior, e.g., excessive shyness or aggressiveness, in the early elementary ages should be targeted for prevention efforts even though approximately half of these children will not develop alcohol or other drug problems or engage in juvenile delinquent acts. Of these children, those who have alcohol-abusing or illegal-drug-using parents should be a primary target.

Conversely, alcohol and other drug use in early adolescence is more frequently associated with antisocial acts. Early initiation also is linked to a higher risk for more extensive use of alcohol and other drugs. The earlier the onset of any drug use, the greater the involvement in other drug use and the greater the frequency of use. Early initiation into drug use increases the probability of extensive and persistent involvement in the use of drugs and the probability of involvement in deviant activities such as crime and selling drugs.

As Erickson pointed out, prevention strategies that do begin early must be developmentally appropriate. Kids under the age of 12 think in concrete, as opposed to abstract, terms: If root beer doesn't contain beer and ginger ale doesn't contain ale, then why should wine coolers contain wine? It is important to communicate with children under age 12 in terms they understand and through agents with whom they feel comfortable.

Most researchers conclude that since the "family" is the main socializing agent for children, families should be involved in childhood, pre-adolescent, and early adolescent prevention efforts.

Establish and Sustain Non-Use Norms for Youth

According to one researcher, permissive parental attitudes toward drug use as perceived by youth may be of equal or greater importance than actual parental drug use in determining much drug use by adolescents. A researcher studying the effectiveness of school-based programs found that once young people found out that "not everyone was smoking and that smoking was considered by peers to be unacceptable," a decrease in smoking behavior occurred.

Conformity to peers is often considered one of the hallmarks of adolescent behavior. Early adolescents' need for affiliation with a group of peers is manifested by conformity to group norms, and the group itself is strengthened when members exert conformity pressures on each other. One study found that young people generally are less likely to be pressured into behavior they perceive as antisocial. The problem arises in the ambivalence of peers, communities, and society as a whole concerning what constitutes antisocial behavior: is alcohol and other drug use considered "normal" or antisocial, acceptable for youth or unacceptable for youth?

Peer modeling and peer norms have significant effects on adolescent drinking, and adolescent drinking results in a higher probability of using other illegal drugs such as marijuana and cocaine. Several researchers have found that social influence is a matter of setting and enforcing standards for

conduct. Therefore, whether an adolescent uses alcohol or other drugs depends a great deal on whether drinking is approved and sanctioned by other people, including parents or guardians, peers, other role models, and the media. In general, the researchers suggest that parental norms about drinking and the drinking behaviors of peers are important predictors of use. These findings suggest that prevention efforts take the form of teaching parents to establish non-use norms and of making adolescents more aware of the fact that most young people do not use cigarettes, alcohol, or other drugs.

In addition, researchers have found that the more pressure adolescents perceive from friends to engage in alcohol and other drug use, the more frequent is their self-reported involvement in these behaviors. Alternatively, the stronger the perceived pressures are against alcohol and other drug use, the more adolescents reportedly refrain from using these substances. The implication is that because of the bidirectional nature of peer pressure, peers are potentially prosocial influences -- thus the term, "positive peer pressure."

Assess the Needs and Target the Efforts

According to many researchers and clinicians, alcohol and other drug use by youth meets a wide range of needs that may have to be examined before launching a prevention or intervention program. Needs may be psychological or social and include the desire to anesthetize oneself from feelings associated with stressful life events; to assert one's maturity, masculinity, toughness, or individuality; to gain group acceptance and feelings of social adequacy or to avoid peer pressure; to compensate for lack of other skills; or to relax, relieve boredom, or celebrate. In some cultures, use of alcohol and other drugs are often used by young people to demonstrate a "higher" status, e.g., a scotch drinker versus a beer drinker. Many young people believe that use of alcohol and/or other drugs gives them a sense of control over their lives, especially in environments in which they have little control. Alcohol and other drugs also have been used throughout history as self-medication. Today's fourth, fifth, and sixth graders believe that the main reasons kids start to use drugs, including alcohol, are to fit in, feel older, have a good time, and avoid feeling bad.

Understanding the expectations that young people hold about the function of alcohol and drug use will be helpful. For instance, researchers have found that young people who believe that their parents expect them to drink or use other drugs are more likely to do so. Youth who believe that drug-taking is expected behavior may, therefore, be at especially high risk. When explored with young people, the need to "fit in" is often translated as "since everyone is doing them, I want to also." Effective programs address the myth that everyone is using alcohol and other drugs, as well as other misconceptions.

Once community leaders and young people understand the reasons why young people are using alcohol and other drugs, they can be brought together to discuss alternatives as part of a prevention strategy. When one group of high school students was asked to think of a different way to engage in risk-taking behavior, they suggested watching the movie "Jaws" in a crowded pool with their peers!

Take a Broad, Environmental Approach

Prevention activities operate in complex social and economic environments in which many variables interact with each other over time. When variables are studied in isolation, it becomes difficult to explore the precise linkage between action and effect, or to assess the impact of concurrently operating prevention efforts.

We know that a variety of factors influence the consumption of alcohol and other drugs by youth and adults alike. These include genetic and biological predisposition; family practices, attitudes, and norms; socialization patterns, peer behaviors, and contacts; community practices (including early use patterns) and norms, as well as the price of alcohol and other drugs; the economic and educational levels of the community; exposure to media and other messages that encourage use; laws about use (such as the legal drinking age or sanctions for use of illegal drugs set

by states); policies determining the availability of substances; and policies and practices that encourage and reward help-seeking behaviors. Consumption by youth also is influenced by role modeling of older siblings, parents, doctors, actors, rock stars, and others.

Although incomplete, the preceding list points to the need for integrated programs with enduring, coordinated, and persuasive strategies that address the many domains of environmental influence on youth and their older role models. Single-target prevention approaches are not successful and cannot possibly compete with the daily contact young people have with many different people, television, music, and reading materials. It is the daily contact through which young people develop their lifestyles and the context in which alcohol and other drug use must be examined.

Prevention efforts in the past have placed the greater emphasis on personalized motives and causes for alcohol and other drug use and as a result have often lost sight of the larger environmental determinants of use. That is, alcohol and drug use among youth is frequently labeled as an individual problem instead of as a social problem. However, when one begins to readdress use as a social problem, solutions take a different shape. For instance, teaching how to "Just Say No" may be even more effective if directed at communities instead of individuals. Families, schools, churches and synagogues, scout troops, boys' and girls' clubs, housing projects, chambers of commerce, and entire communities can make a commitment to "saying no" and to promoting health, safety, and meaningful lifestyles.

As discussed in the models and theories, these efforts must increase awareness; change attitudes; develop skills; provide training and alternatives; allow for trial, adoption, and practice of new behaviors with support from family, friends, classmates, coworkers, and the community; and continually reinforce healthy lifestyles-- whether new or brought forward from childhood. Entire communities can gather information about the problem as it appears in their community, make a commitment to supporting a drug-free community, set goals and objectives, identify resources, and plan rewards and celebrations for meeting their goals.

The importance of a well-rounded approach to prevention cannot be overemphasized; a problem attacked from many directions has a better chance of being solved than does a problem addressed from a single-solution orientation.

NEEDS ASSESSMENT

Before planning a prevention effort, a good deal of information is needed. This information includes the level of alcohol and other drug problems in the community and existing prevention and intervention programs.

Assessment involves judging or determining the importance, size, or value of something. If you find that an alcohol or drug problem does exist in your community – and most communities will – it is important to take an in-depth look at your community and make some judgments and decisions about how to proceed with your prevention efforts. Needs assessment can help uncover concerns of highest priority. It can also help to define objectives, which may help uncover concerns of highest government priority. The objectives should be established within the framework of overall goals.

The common goal of prevention and intervention efforts is to reduce the incidence of alcohol- and other drug-related problems. Prevention measures are addressed to large populations, including those who may not yet drink or take other drugs. Intervention strategies are targeted to more discrete groups of individuals:

- those who consume alcoholic beverages either heavily, frequently, or under conditions that endanger health, life, or property;
- those who abuse prescription or over-the-counter drugs either alone or in combination with other drugs, including alcohol; and
- those who use illegal drugs, including underage youth who use alcohol.

The specific goal of intervention is to help these people obtain early treatment or to modify their behavior to eliminate or minimize the risk of developing further problems. The specific goal of prevention programs, on the other hand, is to prevent problems before any symptoms have occurred. Interpretation and emphasis often determine whether a particular measure is defined as prevention or as intervention.

Questions you might ask to assess the needs of your community include:

1. What do community members know about alcohol and drugs? What are their attitudes toward these substances? How many people use them and how much do they use? Breaking these data out by age, sex, ethnicity, income, and other demographic characteristics of respondents provides a clearer picture of the community.

2. Where, when, and with whom do community members use alcohol and other drugs? In other words, what is the context of use? Sometimes aiming a prevention effort at the context of a problem is more effective than aiming it at individual users.

3. Which high-risk factors for use of alcohol and drugs by youth, and for abuse by adults, are relevant to your community members? For instance, it may be important to ascertain the family norms, consumption patterns, and attitudes of different peer groups, as well as the community attitudes concerning the use of alcohol and other drugs by minors.

4. Is there a significant population, such as children of alcoholics or illegal drug users, that may require more intensive efforts?

5. What and who are the credible and respected sources of information in your community?

Answers to many of these questions are sometimes attainable from state departments of health, alcohol and drug abuse, mental health, education, and transportation. University consultants from a variety of disciplines and private research companies often supply information as well. Further information on conducting a needs assessment can be obtained from the National Clearinghouse for Alcohol and Drug Information at (301) 468-2600.

CONCLUSIONS

Public opinion polls and other measures show that adults and young people alike are aware of the seriousness of the alcohol and drug problem in this country. Having raised the public's consciousness to these issues, prevention can now move forward.

One thing that appears certain is that the causes of alcohol and other drug use are complex. For that reason, confronting the problem from a single direction is not likely to be effective. Community members and groups need to work together to make a difference and to form a united voice against alcohol and drug use by their youth. More than thirty five national voluntary and professional associations representing approximately 30 million people have made a commitment to preventing alcohol and other drug problems among the nation's youth.

These efforts can be enhanced by state and local governments. States and localities need to be involved in community needs assessment. Development of mutual common strategies will complement the efforts of community members and groups. The support of multiple governmental agencies, particularly educational institutions, will be required. And finally, the focus on community prevention efforts may require the reallocation of state and local resources toward this end.

Resources

Health Education Quarterly, Volume 12, Number 2, Summer 1985.

Journal of Children in Contemporary Society, Volume 18, Number 1 and 2, Fall/Winter 1985.

Journal of School Health, Volume 56, Number 9, November 1986.

National Institute on Alcohol Abuse and Alcoholism. Sixth Special Report to the U.S. Congress on Alcoholism and Health, January 1987.

National Institute on Drug Abuse. Preventing Adolescent Drug Abuse: Intervention Strategies, Research Monograph #47, 1983.

Preventive Medicine, An International Journal Devoted to Practice and Theory, Volume 15, No. 5, September 1986.

PART THREE: Alcohol and Drug Abuse Prevention Programs in the States

INTRODUCTION

The task force chair, Governor Martha Layne Collins, sent a survey letter to each Governor requesting information on state drug strategies, effective state initiatives in alcohol and drug abuse prevention, and the name of the state program coordinator for substance abuse programs.

Information was received from many states. Information on substance abuse programs in states that did not respond to the survey letter was collected from several reports, including the 1984 Task Force on Substance Abuse Prevention report by the National Conference of Lieutenant Governors. This report involves an extensive review of state and local programs.

Information also was provided by the National Association of State Alcohol and Drug Abuse Directors (NASADAD). A 1985 study that NASADAD conducted for the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse, "An Analysis of State Alcohol and Drug Abuse Profile Data," was very helpful.

SUMMARY OF ALCOHOL AND DRUG ABUSE PROGRAMS IN THE STATES

Alabama

The Alabama Department of Mental Health acts as the sole funding and rulemaking authority for programs in the state. Its prevention section works with local volunteer and private, non-profit programs to provide a variety of activities.

The prevention section is the primary state agency working with alcohol and drug education programs in the schools. There are a total of thirty-one programs statewide that have prevention activities. The majority of programs on the local level are run by community mental health centers.

In addition to developing school curricula, the state prevention section has worked with the Office of Highway and Traffic Safety to provide information to junior and senior high classes. The department also has initiated alcohol projects on college campuses along with the state's Alcohol Beverage Control Board.

The prevention section also works with parent/teacher groups, establishing a statewide parents' consortium. There are also programs for the elderly and specialized workshops for professional groups. For more information, contact:

Division of Mental Illness and Substance
Abuse Community Programs
200 Interstate Park Drive, Box 3710
Montgomery, Alabama 36193
Mary Lee Rice, Director
(205) 271-9253

Alaska

State law mandates that programs funded by the State Office of Alcoholism and Drug Abuse (SOADA) receive grants-in-aid. SOADA-funded grant recipients are required to demonstrate that local planning and input have gone into the development of the program. A local policy or advisory board is required for all projects.

Community program grants require a minimum of 10 percent in financial match in order to receive state funds. With many local programs, the required match is 50 percent or more. Programs are held accountable through annual on-site evaluations and biannual fiscal audits. For more information, contact:

State Office of Alcoholism and Drug Abuse
Department of Health and Social Services
Post Office Box H-05-F
Juneau, Alaska 99811-0607
Matthew Felix, Coordinator
(907) 586-6201

Arizona

Drug and alcohol abuse programs in the state are funded and supervised by separate sections under the state Department of Health Services. Local programs are required to provide matching funds for state contracts.

Programs are funded according to the priority populations of children and adolescents, women, parents and families, minorities, and the elderly. Department funds support five types of prevention programming: education and training, media, community development, alternatives, and program consultation. Each local recipient of funds provides a variety of programs aimed at specific target groups. Programs are required to perform process and outcome evaluations, using individualized evaluation designs. For more information, contact:

Alcohol Abuse Section
Division of Behavioral Health
701 East Jefferson
Suite 400A
Phoenix, Arizona 80534
Michael Schwegler
(602) 255-1152

Arkansas

The Governor of Arkansas recently announced the establishment of a Professorship on Alcohol and Drug Abuse Prevention and an endowed Chair on Alcoholism and Drug Abuse Studies at the University of Arkansas for Medical Sciences. The professorship is in the College of Pharmacy and was made possible through a grant from the Arkansas Department of Human Services' Alcohol and Drug Abuse Prevention (OADAP) division. The endowed chair will be in the College of Medicine and was made possible through a challenge grant from OADAP. Other funds for this Chair will be raised from a temporary, legislatively imposed alcohol beverage tax.

In addition, OADAP funds and supervises school and community-based programs in the areas of primary prevention and education of drug and alcohol abuse. Efforts are made to involve youth in all project planning and implementation. All programs are encouraged to recruit volunteers, and community participation is heavily weighed when programs are selected for funding. For more information, contact:

Office on Alcohol and Drug Prevention
1515 West 7th Street, Suite 310
Little Rock, Arkansas 72202
Paul T. Behnke, Director
(501) 371-2604

California

The state's Department of Alcohol and Drug Programs is divided into alcohol and drug divisions. Most of the federal and state dollars for prevention are distributed to the state's fifty-eight counties, which in turn administer and fund local programs.

Both divisions are involved in prevention activities as well. The department as a whole coordinates a statewide parent/community prevention effort, including networking, parent training, information dissemination, and media campaigns. The department is also responsible for monitoring county-operated school and community-based projects.

There are 636 programs in the state of California that provide some type of drug abuse and/or alcoholism prevention services. They range from treatment facilities to school-based groups to community groups. For more information, contact:

Division of Alcohol Programs
111 Capitol Mall
Sacramento, California 95814
Susan B. Blacksher, Chief

Colorado

The Alcohol and Drug Abuse Division of the Colorado Department of Health is the funding authority for prevention programs in the state. It has developed a statewide service delivery system offering many strategies directed at such target populations as high-risk youth, ethnic minorities, and women.

There are school programs, community-based projects, and worksite programs, providing various degrees of information, education, intervention, and alternatives. For more information, contact:

Communities for a Drug-Free Colorado
136 State Capitol
Denver, Colorado 80203
Julie Fagan, Project Director
(303) 866-2885

Connecticut

The Alcohol and Drug Abuse Commission, a free-standing state agency, is responsible for funding and overseeing programs in the state. Funds are distributed on a statewide basis.

Drug and alcohol education is mandated, but there are no specifications for curricula. For more information, contact:

Alcohol and Drug Commission
999 Asylum Avenue
Hartford, Connecticut 06105
Donald J. McConnell, Executive Director
(203) 566-4145

Delaware

The Bureau of Alcoholism and Drug Abuse, part of the Department of Health and Social Services' Division of Mental Health, funds and oversees programs.

The state's primary prevention contractor, the Resource Center, is charged with providing assistance to and networking activities of the state's parent groups and SADD chapters. There are more than thirty-five parent groups and fifteen SADD chapters in Delaware. In addition, some schools use the "Here's Looking at You Two" K-12 curriculum. For more information, contact:

Bureau of Alcoholism and Drug Abuse
Connecticut Building, 2nd Floor
1901 North DuPont Highway
New Castle, Delaware 19720
Sara Taylor Allshouse, Bureau Chief
(302) 421-6101

Florida

The state authority oversees funding and program requirements for prevention efforts in Florida.

A full range of programs can be found, ranging from parents groups to school-based substance abuse prevention programs.

Founded in 1979, the Florida Informed Parents organization is composed of eighty-six parent groups, with membership totalling about 10,000. Focusing on school-age drug use, the organization provides workshops, conferences, and parent peer groups. The Florida State Cabinet has commended the organization for its work in coordinating the Chemical People program in Florida. Florida Informed Parents demonstrates the unique value of the parent movement, coordinating law enforcement, schools, churches, and civic groups in working toward a common goal of drug-free youth. The group's philosophy is that a community must work together to establish a policy that drug use is not acceptable for its young people, and that policy must be clearly communicated to the youth. For more information, contact:

Alcohol and Drug Abuse Program
1317 Winewood Boulevard
Tallahassee, Florida 32301
Linda Lewis, Administrator
(904) 488-0900

Georgia

The Department of Human Resources is the sole funding authority for drug and alcohol abuse programs. The department distributes federal block grant dollars to local mental health agencies. The Alcohol and Drug Services Section provides technical assistance to local programs.

In addition, the Prevention Unit of the Division of Mental Health and Mental Retardation has developed a program for school-age children. Life Skills for Mental Health teaches youth problem-solving skills and ways to handle pressure to use drugs. Twenty-six community mental health centers across the state have teams trained to conduct workshops and follow-up for teachers, and other youth workers to learn to use the program. For more information, contact:

Alcohol and Drug Services Section
878 Peach Street, Northeast
Suite 319
Atlanta, Georgia 30309
Patricia Redmond
(404) 894-4785

Hawaii

The Alcohol and Drug Abuse Branch of the Department of Health is the single state authority for funding. Part of the Division of Mental Health, the branch works with the Office of Primary Prevention to review program proposals and to monitor existing programs.

Funds for prevention programs are distributed on a statewide basis to private contractors. The state branch does program planning, development, and coordination.

Alcohol and drug education is not mandated, but some schools use a K-12 curriculum through the state Department of Education. There are also seventeen Chemical People task forces throughout the state. For more information, contact:

Alcohol and Drug Abuse Branch
Honolulu, Hawaii 96801
Joyce Ingram-Chin, Branch Chief
(808) 548-4280

Idaho

The Substance Abuse Section of the Department of Health and Welfare directly funds the three programs. The programs' main focus is on reducing the incidence of alcohol and substance abuse problems in youth.

The remainder of the state's programs are funded and administered on the county level. For more information, contact:

Bureau of Substance Abuse
Department of Health and Welfare
450 West State Street
Boise, Idaho 83720
Ray Winterowd, Chief
(208) 334-5935

Illinois

Drug and alcohol programs currently are administered by separate agencies in the state government. The two oversee funding and set standards and operate out of regional offices. Programs are operated at the local level by various local government entities and private, non-profit agencies.

Illinois has a strong community-based system of programs, which include agencies, teen peer leadership groups, and parent groups. Standard treatment programs are supported by stringent DUI laws, a narcotics trafficking confiscation law, and treatment alternatives to incarceration.

As a result of the "Chemical People" project, at least ninety-six community task forces have been formed, bringing the state total of community and parent organizations to about 180. For more information, contact:

Illinois Alcoholism and Drug Dependence Association
628 East Adams
Suite 204
Springfield, Illinois 62701
James Long
(217) 528-7335

Indiana

The Division of Addiction Services of the Department of Mental Health directly funds local prevention programming through requests for proposals. Local programs must be incorporated and can be profit or non-profit. Program efforts are coordinated by the state on a regional basis.

The division, in conjunction with the state Department of Public Instruction, has developed a curriculum guide for drug and alcohol education. Such education is mandated at the elementary level and is offered as anelective at the secondary level. For more information, contact:

Division of Addiction Services
117 East Washington Street
Indianapolis, Indiana 46204-3647
Joseph E. Mills III

Iowa

The Governor of Iowa has established the "Governor's Alliance on Drug Abuse" with a three-point comprehensive program including drug education, treatment, and prevention; tougher penalties for drug pushers; and stronger enforcement of drug laws. In October 1986, eight correctional facilities were opened for individuals convicted of operating a motor vehicle while intoxicated. These facilities offer a combination of treatment, supervised living, and employment opportunities. For more information, contact:

Iowa Department of Public Health
Lucas State Office Building
Des Moines, Iowa 50319
Mary Ellis, Director
(515) 281-5605

Kansas

Programs are funded by a single state agency, the Department of Social and Rehabilitation Services/Alcohol and Drug Abuse Services. The prevention division offers program development for community-based programs and agencies, school programs, technical assistance, training and staff development for parent support groups, and family health promotion. The agency also offers employee assistance programs and conducts public information campaigns.

While not advocating a particular model curriculum, the state does use the School Team approach developed by the U.S. Department of Education, including "teaming the athletic peer group." The state agency also coordinates Students Against Driving Drunk chapters. For more information, contact:

Alcohol and Drug Abuse Services
Biddle Building, Topeka State Hospital
2700 West 6th Street
Topeka, Kansas 66606
Commissioner
(913) 296-3925

Kentucky

"Champions Against Drugs," the prevention initiative of the Kentucky Governor, is a public education and community mobilization campaign. The public education portion utilizes Kentucky sports figures and other well-known individuals to speak out against alcohol and drug abuse and to encourage citizens to become involved in prevention programs. Statewide, seventeen regional action groups currently are working to develop comprehensive strategies to address alcohol and drug problems at the state, regional, and community levels. The four-pronged approach to comprehensive programming includes public awareness, education and training (with a special emphasis on youth leadership training), intervention and treatment, and law enforcement. The program emphasizes collaboration at the state and community levels to build on and expand existing

service networks. The law enforcement component will conduct sixteen public hearings across the state and prepare recommendations and a legislative packet to present to state legislators during the 1987 session. There are more than sixty communities in Kentucky that have active citizen groups supporting programs to prevent the spread of drug problems, and there are at least fifty "Just Say No" clubs promoting drug-free activities and positive peer pressure for youth. For more information, contact:

Division of Substance Abuse
275 East Main Street
1st Floor, East Wing
Frankfort, Kentucky 40621
Michael Townsend, Director
(502) 564-2880

Louisiana

The Department of Health and Human Resources' Office of Prevention and Recovery from Alcohol and Drug Abuse provides alcohol and drug abuse prevention and treatment services through a number of facilities and programs, including:

- promotion and participation in major statewide substance abuse prevention campaigns, including Substance Abuse Awareness Week, Drunk and Drugged Driving Awareness Week, Be Smart Don't Start, Fetal Alcohol Syndrome Awareness Week, and Operation Prom/Graduation.

- six halfway houses for individuals recovering from substance abuse.

- six community-based outpatient treatment programs for drug and alcohol abuse funded through contracts. One of these programs (in Lake Charles, Louisiana) serves primarily adolescents and provides extensive prevention and early intervention services.

- four inpatient treatment facilities. Two of these facilities (one in Shreveport and one in Lake Charles) also provide detoxification services.

- twenty-four state-operated outpatient treatment clinics located throughout the state. Clinics provide substance abuse treatment, prevention, and early intervention services. For more information, contact:

Office of Prevention and Recovery from
Alcohol and Drug Abuse
2744 B Wooddale Boulevard
Baton Rouge, Louisiana 70805
Rupert Richardson
(504) 922-0721

Maine

The Office of Alcoholism and Drug Abuse Prevention coordinates efforts in the state. In addition, three other state agencies are involved in prevention activities.

The Maine Alcohol and Drug Abuse Clearinghouse is a function of the Department of Human Services' Bureau of Health, Division of Health Education. It serves as a central source for information about alcohol and other drugs, substance abuse prevention, treatment, research, and education. The clearinghouse also provides technical assistance and consultation in prevention program development. For more information, contact:

Division of Alcohol and Drug Education Services
Stevens School Complex
State House, Station 57
Augusta, Maine 04333
Carl D. Mowatt, Director
(207) 289-3876

Maryland

Programming in the state is funded and supervised by separate sections within the Department of Health and Mental Hygiene. In addition to the programs listed in this section, there are a number of Chemical People task forces, many SADD chapters, and "Tough Love" groups.

The Alcohol and Drug Abuse Prevention Program also funds an additional twenty-six community development prevention programs statewide. Activities range from school-based prevention, peer leadership, parent education, and grass-roots networking. Regional coordinators cover the state to plan, coordinate, and advocate local services. The state office operates a direct elementary school-based effort, the "Kool Pat – Little Moe" decisionmaking program. For more information, contact:

Alcoholism Control Administration
201 West Preston Street, 4th Floor
Baltimore, Maryland 21201
Darlind Davis, Assistant Director
(301) 225-6555

Massachusetts

The Governor of Massachusetts created the "Governor's Alliance Against Drugs" in December 1984. The program is a coordinated statewide effort that has mobilized communities to confront the issue of student drug and alcohol abuse. In its first year, the alliance enlisted the support of more than 200 Massachusetts communities in an effort to combat substance abuse among young people. The program entails counseling services for youth and their families, teacher training/program development, regional primary prevention centers, youth residential treatment, and identification of high-risk youths. For more information, contact:

Governor's Alliance Against Drugs
1 Ashburton Place, Room 2131
Boston, Massachusetts 02108
Marianne Lee, Deputy Director
Drug Program Coordinator

Michigan

The major prevention licensing category is called CAIT, reflecting the state's priorities of community change, alternatives, information, and training. Licensed programs include private, state, and locally supported efforts. The types of services offered range from community-based information activities to school-based education programs and Alcohol Highway Safety Education services.

Michigan recently completed a five-year prevention plan, developed at the state-level with input from local programs and communities through the state Prevention Advisory Council. The plan focuses on state and local efforts in six major "core" services, including preschool education, school health curriculum, parent/teacher peer training, community-based prevention services, mass media influence, and employee health promotion.

Current state policy requires that any new state funding allocated to prevention be utilized for the improvement or development of the services described in the plan. For more information, contact:

Office of Substance Abuse Services
3423 North Logan Street
Lansing, Michigan 48909
Robert Brook, Administrator
(517) 373-8603

Minnesota

The Chemical Dependency Program Division of the Department of Human Services is the single state authority for drug and alcohol programs. The office administers federal block grants and state funds. While some programs must participate in the proposal request process yearly, the office also funds long-term projects on a three-year basis.

There are many programs for the state's sizeable Native American population, for which there is a citizens' advisory board. The state office is currently working on special projects for Spanish-speaking citizens.

While the Chemical Dependency Program Division does not license, it does provide technical assistance to local programs. It has established the Minnesota Prevention Resource Center to work with local programs, including providing "seed" money for new projects. There are about 415 chemical abuse prevention task forces in Minnesota.

Minnesota has an extensive school drug/alcohol education program, which is supervised by the state Department of Education. Alcohol and drug education is mandated, and the state reimburses school districts for their programs. Many schools work with the Prevention Resource Center on program development. For more information, contact:

Chemical Dependency Program Division
444 Lafayette Road
St. Paul, Minnesota 55155
Cynthia Turnure, Director
(612) 296-4610

Mississippi

The Division of Alcohol and Drug Abuse of the Department of Mental Health funds programs throughout the state on a regional basis. The programs include community mental health centers, free-standing programs, state hospitals, and state universities. The division also supports an in-house clearinghouse with written materials and a film library. Specialized prevention activities also are planned at the state level. For more information, contact:

Division of Alcohol and Drug Abuse
1500 Woolfolk Building
Jackson, Mississippi 39201
Anne D. Robertson, Director
(601) 359-1297

Missouri

The Governor recently announced a six-part drug and alcohol abuse initiative designed to forge a partnership between state and local groups toward preventing drug and alcohol abuse. The plan,

called "MO say NO to Alcohol and Drug Abuse," provides a coordinated response to the problem of substance abuse in the state. Among the initiative's goals are creating local responses to local problems by forging a partnership between schools and community groups; teaching students about the dangers of alcohol and drug abuse by improving the alcohol and drug abuse curriculum; and identifying and treating young people with drug problems through early intervention efforts. The initiative is the work of a team of state government experts in the areas of health, public safety, schools, mental health, and youth. For more information, contact:

Division of Alcoholism and Drug Abuse
Department of Mental Health
1915 South Ridge Drive
Jefferson City, Missouri 65102
Lois Olson, Director
(314) 751-4942

Montana

Programs in the state are funded and supervised by the Alcohol and Drug Abuse Division of the Department of Institutions. The state is divided into five regions. Every outpatient chemical dependency program provides some type of prevention and/or early intervention activity on an on-going basis.

An on-going program brings parents and teenagers together in both peer groups and family units. Three areas of discussion deal with drinking and driving, alcohol and drug use, and their effects. Parents and teens focus on solving problems, expressing feelings, making decisions, and communicating.

A structured group therapy experience for first offense adolescent drug and alcohol abusers uses peer relationships to aid them in changing their lifestyles. The program is intended to be an alternative to suspension/expulsion or incarceration. Consisting of eight two-hour sessions over an eight-week period, the groups work on heightening self-esteem, improving communication skills, fostering interpersonal relationships, and aiding members in setting personal goals. For more information, contact:

Alcohol and Drug Abuse Division
1539 11th Avenue
Helena, Montana 59624
Bob Anderson, Administrator
(406) 444-3904

Nebraska

The Division on Alcoholism and Drug Abuse of the Department of Public Institutions is the single state funding authority for prevention programs. The division was created when two separate commissions were consolidated by legislative mandate several years ago. The division funds only prevention programs; regional governing boards fund only treatment programs.

Alcohol and drug education is mandated, but the state's school districts may implement it as they choose. The division has worked with the state Department of Education to develop a curriculum, "Decisions About Alcohol and Other Drugs," which is available to state schools. In addition, the state authority has produced a videotape, "Resisting Pressures to Drink and Drive." For more information, contact:

Division on Alcoholism and Drug Abuse
P.O. Box 94728
Lincoln, Nebraska 68509-4728
Cecilia Doughty Willis, Director
(402) 471-2851

Nevada

Programs are funded and supervised by the Bureau of Alcohol and Drug Abuse of the Department of Human Resources. The bureau also has set up tutoring programs on Indian reservations and in juvenile probation centers. It distributes a newsletter, the "Alcothon," has organized Families Anonymous and Tough Love groups, has a resource library, and provides technical assistance to local programs.

The bureau provides training and curriculum materials to the state's public and private schools, including the "Starting Early" and "Alcohol Awareness" programs for junior and senior high schools and the "Positive Action" program.

There are also twelve Chemical People task forces located throughout the state. For more information, contact:

Bureau of Alcohol and Drug Abuse
505 East King Street, Room 500
Carson City, Nevada 89710
Richard Ham, Chief
(702) 885-4790

New Hampshire

Substance abuse programs are divided between treatment and intervention programs. For those who are at risk to develop a potentially serious substance abuse problem, intervention programs are appropriate. When the individual and/or family is directly affected by substance abuse or addiction, treatment services are involved.

The state owns and operates a halfway house for recovering male alcoholics. Other services are provided through contracts with non-profit agencies and organizations. Public funding supports outpatient counseling at twenty-one separate locations throughout the state, two twenty-eight-day residential programs for the treatment of alcoholism, beds purchased in two therapeutic communities that treat the multi-problem substance abuser, funding of seven crisis intervention centers developed to care for the publicly inebriated, and financial support for one halfway house for women.

Seven Crisis Intervention sites are located in the state. The primary audience of these sites are individuals who are suffering intoxification from alcohol and who are not in a medical emergency. The staff is composed of volunteers who are specifically training in the management of the inebriate and Emergency Medical Technicians. For more information, contact:

Office of Alcohol and Drug Abuse Prevention
Health and Human Services Building
#6 Hazen Drive
Concord, New Hampshire 03301-6525
Geraldine Sylvester, Director
(603) 271-4627

New Jersey

The Governor of New Jersey is calling for the creation of an "Alliance for a Drug Free New Jersey." The alliance calls for business, law enforcement, religious, education, and community leaders to establish a statewide program against substance abuse. It plans to solicit New Jersey's 567 cities and towns in an effort to abolish drug abuse. The aims of the alliance include:

- organizing and coordinating the efforts of school, police, business groups, and other community organization to fight drug abuse;
- adopting a K through 12 drug abuse education program in the schools that have been determined to be comprehensive and effective;
- adopting clear procedures for the intervention, treatment, and discipline of students abusing alcohol and drugs;
- providing a comprehensive drug abuse education and outreach program for parents; and
- providing a comprehensive substance abuse community awareness program.

The program focuses heavily on the demand side and seeks to make sure that every child in the New Jersey public school system receives drug abuse education. The primary strategies focus on prevention, intervention, and treatment. Prevention programs are geared toward limiting the demand for drugs through increased public awareness, community activity, and parental support. Intervention programs seek to identify drug abusers at the earliest point and encourage their participation in appropriate treatment programs. For more information, contact:

Division of Alcoholism
Department of Health
129 East Hanover Street
Trenton, New Jersey 08625
Riley W. Regan, Director
(609) 292-8949

Division of Narcotic/Drug Abuse Control
129 East Hanover Street
Trenton, New Jersey 08625
Richard J. Russo, Director
(609) 292-5760

New Mexico

Programs in the state are funded and supervised by the Behavioral Health Services Division of the Health and Environment Department. There is a heavy emphasis on community involvement, particularly for youth and the elderly. Many community agencies sponsor an alternative prevention education drop-in center for youth ages 6 to 19. In addition, there are programs for the elderly. Several Native American groups have specialized programs for their members. For more information, contact:

Drug Abuse Bureau
P.O. Box 968
Santa Fe, New Mexico 87504
Ron Coss, Acting Chief

Alcoholism Bureau
P.O. Box 968
Santa Fe, New Mexico 87504
Arturo Rangel, Chief
(505) 827-2587

New York

Programs in the state are funded and overseen by the Division of Substance Abuse Services of the Office of Alcoholism and Substance Abuse. Prevention programs are funded through the counties, which then sub-contract to non-profit community-based and school-based agencies. Funding is provided for about 146 prevention programs, with assistance to another fifty-six community groups.

There are also county councils on alcoholism that provide information and referral services as well as prevention and education programming. In addition, there are programs that receive state and local funding under a local assistance formula, and that do not report to the division.

The division centrally operates a Fetal Alcohol Syndrome/Alcohol Related Birth Defects prevention and education program as well as statewide information and awareness campaigns. For more information, contact:

Division of Alcoholism and Alcohol Abuse
194 Washington Avenue
Albany, New York 12210
Robert V. Shear, Director
(518) 474-5417

North Carolina

The Governor has created the Governor's Council on Alcohol and Drug Abuse Among Children and Youth to bring to the state a new awareness of this problem. The council is charged with reviewing and making recommendations to the Governor on youth substance abuse issues. It reviews and recommends mechanisms for coordination of state and local resources; conducts public hearings; promotes local boards, councils, or commissions to identify model prevention, intervention, and treatment efforts for possible statewide replication; and conducts public awareness activities.

The Governor challenged every local community to form a local task force or coalition on substance abuse. A statewide conference will be held in the fall for local officials, law enforcement personnel, business leaders, education officials, health organizations, and civic leaders to share information and build a solid foundation for addressing the drug problem. At the forum, a booklet with information on every anti-drug effort at the state level will be released.

The Office of Alcohol and Drug Services, of the Department of Human Resources' Division of Mental Health, Mental Retardation, and Substance Abuse Services is the single state agency for drug and alcohol programs.

Prevention programming on the local level is carried out by area mental health agencies, which either provide direct services or contract with private, non-profit agencies.

Drug and alcohol education is mandated in state schools. The Office of Alcohol and Drug Services works cooperatively with the state Department of Education to implement curricula. For more information, contact:

Alcohol and Drug Abuse Services
Division of Mental Health, Mental Retardation and Substance Abuse Services
325 North Salisbury Street
Raleigh, North Carolina 27611
Tom Miriello, Deputy Director
(919) 733-4670

North Dakota

The Division of Alcoholism and Drug Abuse of the Department of Human Services funds and supervises programs in the state. The state is divided into regions for program administration.

Activities sponsored by the division include media campaigns focused on youth and responsible adult drinking, with special campaigns around the holidays offering alternatives to alcoholic beverages and responsible drinking and driving. Youth media campaigns and educational programs focus on peer group resistance and individual responsibility. In addition, the division provides curriculum guides, speakers, and information resources. For more information, contact:

Division of Alcoholism and Drug Abuse
State Capitol, Judicial Wing
Bismarck, North Dakota 58505
John J. Allen, Director
(701) 224-2769

Ohio

Alcohol and drug abuse programming in the state is overseen by two authorities. The Bureau of Alcohol Abuse and Alcoholism Recovery awards state and federal funds, coordinates programs, and sets standards. It also funds the state's alcoholism counselors certification program and sponsors the annual Teenage Institute for the prevention of alcohol and other drug abuse. The Bureau of Drug Abuse provides similar supervision and support for drug programs.

Planning, implementation, and coordination of alcoholism programs on the local level is done by twelve regional councils, made up of citizens from each region. For more information, contact:

Department of Mental Health
Office of Education and Training
30 East Broad Street, 13th Floor
Columbus, Ohio 43215
(614) 466-9902

Oklahoma

The state Department of Mental Health is the single state authority funding and overseeing drug and alcohol abuse programs. The department is divided into divisions for the administration of programs. Prevention programming is funded on the basis of statewide pilot demonstration projects that must submit competitive bids.

Drug and alcohol education is not mandated in the state, and no one curriculum is endorsed. For more information, contact:

Alcohol and Drug Programs
P.O. Box 53277, Capitol Station
Oklahoma City, Oklahoma 73152
Tom Stanitis, Director
(405) 521-0044

Oregon

Prevention services in the state are funded and supervised by the Office of Programs for Alcohol and Drug Problems, Division of Mental Health, Department of Human Resources. Rules and guidelines are established by the state. Management of services is done jointly between state and county governments.

State funding guidelines recommend that programs be targeted toward elderly, adolescents, children of alcohol and drug abusers, and women. Programs at the local level include student assistance, peer counseling, and school prevention curriculum. There are also DUI education and treatment programs, media campaigns, prescription drug abuse prevention efforts, employee assistance programs, Channel One projects, and facilitation of parent groups to fight drug abuse. For more information, contact:

Programs for Alcohol and Drug Problems
301 Public Service Building
Salem, Oregon 97310
Jeffrey N. Kushner, Assistant Director
(503) 378-2163

Pennsylvania

The Drug and Alcohol System was primarily a treatment-based system until 1980. With the onset of the federal block grants, Pennsylvania was required to spend 20 percent of all federal funds on prevention or early intervention services. In addition, the Office of Drug and Alcohol Programs (ODAP) established a policy that required at least 10 percent of all state monies to be used for prevention services. With a $42 million appropriation, ODAP spends approximately $4.2 million on prevention and early intervention services.

The majority of the $4.2 million is allocated to the Single County Authorities or county agencies to develop and implement prevention/intervention programs that meet the needs of Pennsylvania's diverse population. However, ODAP retains some of these funds to enable it to develop and implement special statewide initiatives such as Teen Pregnancy, Underage Drinking and Driving Programs, and Student Assistance Programs. In addition, interagency contracts have been established and continued with the Departments of Education, Corrections, and Public Welfare to develop and implement programs for school-age children and criminal justice clients.

The office also has obtained grants from the Pennsylvania Commission on Crime and Delinquency and the Department of Transportation to support efforts for juvenile offenders with drug and alcohol problems, and for Driving While Under the Influence offenders. For more information, contact:

Office of Drug and Alcohol Programs
P.O. Box 90
Harrisburg, Pennsylvania 17108
Jeannien Peterson, Deputy Secretary
(717) 787-9857

Rhode Island

The Division of Substance Abuse of the Department of Mental Health, Retardation, and Hospitals is the single state authority for funding and supervision of prevention programs. The division funds local private, non-profit contractors on an annual basis and provides training services, community assistance, and information materials There are also seventeen parent groups, many having grown out of the Chemical People program.

The Division of Alcohol and Drug Abuse is the single state funding authority. It funds and oversees three regional resource centers, which coordinate local efforts. The division also directly funds some local programs. It has targeted school curriculum development, working with state schools to implement alcohol and drug education. The division also contracts with local treatment facilities that provide some prevention information. For more information, contact:

Division of Substance Abuse
Substance Abuse Administration Building
Cranston, Rhode Island 02920
William Pimentel, Assistant Director
(401) 464-2091

South Carolina

The South Carolina Commission on Alcohol and Drug Abuse provides funding and technical support for the state's prevention programming. On the local level, programs are administered by county commissions of alcohol and drug abuse.

The state has developed several model programs that are used locally. These include the School Intervention Program which began in 1978. The program involves local commissions and school districts in an effort to reduce alcohol and drug abuse and/or anti-social behaviors among students in grades 7 to 12.

Other programs include the Counseling and Referral Elective, a type of employee assistance program, and the Alcohol/Drug Safety Action Program, an intervention system designed to reach the drinking driver and the minor drug offender with educational and counseling rehabilitation. Under the program, a first-offense DUI violator may receive a provisional license, and contingent upon successful completion of the drug program, an offender may be eligible for expungement of his or her arrest record.

The commission also has established the Addictions Coordinators Network, which includes nine primary prevention services projects, two prevention volunteers projects, and four community-based prevention projects. For more information, contact:

Commission on Alcohol/Drug Abuse
3700 Forest Drive
Columbia, South Carolina 29204
William J. McCord, Director
(803) 734-9520

South Dakota

The state addresses alcohol and drug abuse problems through the assignment of responsibilities to those state agencies that have the appropriate jurisdiction and expertise. The agency most directly responsible takes the initiative. When areas overlap and involve a number of agencies, coordination of roles takes place among involved state, local, and federal agencies.

According to South Dakota law, mandatory posting of warnings in all places selling alcoholic beverages must advise the dangers of drinking alcohol while pregnant or nursing a baby.

These are several programs for substance abuse prevention in the state; among them is "Solutions," which is composed of teenagers who use theater and group discussion to help young people and adults deal with problems that involve alcohol and drug abuse. These groups are trained to develop scenes that an audience may identify with in order to help people clarify their values concerning social issues. The goal is to help people think through and make decisions beneficial to their health and well-being.

Another program is the school team approach training, where the primary objective is to assist participating schools in prevention and reducing drug and alcohol abuse and associated disruptive behaviors. This is facilitated by encouraging and enhancing the development of a cooperative systems management approach to school governance in which the entire community assumes responsibility for problems and takes part in solution; and by facilitating the creation and maintenance of a positive school environment to reduce disruptive behavior. For more information, contact:

Division of Alcohol and Drug Abuse Services
Joe Foss Building
Pierre, South Dakota 57501
Bob Anderson, Director
(605) 773-3123

Tennessee

The Department of Mental Health and Mental Retardation has been designated the sole authority in the state for alcohol and drug programs. The Division of Alcohol and Drug Services administers funds and oversees programs development.

On the local level, needs assessments are carried out by regional planning boards, which include service division contracts directly with local programs for services. Community mental health centers do about three-fifths of the programming.

Drug and alcohol education is required by the state, and both the state Department of Education and the division offer curricula. In addition, the division offers teacher training for its K-6 curriculum.

The parent movement in the state is fairly new. There are about eight active groups, including MADD and RID chapters. For more information, contact:

State Planning Office
309 John Sever State Office Building
500 Charlotte Avenue
Nashville, Tennessee 37219-5082
Carol White, Federal Affairs Coordinator
(615) 741-1676

Texas

Drug and alcohol abuse prevention programs are funded and overseen by two separate state agencies. The Commission on Alcoholism administers programs through regional authorities. The state is divided into twenty-four regions.

The Drug Abuse Prevention Division of the Department of Community Affairs handles drug programming. Both agencies provide technical assistance, training, and program planning and development. For more information, contact:

Commission on Alcoholism
1705 Guadalupe Street
Austin, Texas 78701
Ross A. Newby, Director
(512) 463-5510

Drug Abuse Prevention Division
2015 South 1H 35
Austin, Texas 78741
Jim Bradley, Director
(512) 463-5510

Utah

The State Division of Alcoholism and Drugs coordinates education, prevention, and training programming statewide. It oversees planning and contracting for programs at the local level, providing links with other state-level agencies (such as mental health, aging, education, PTA, and the legislature) and also provides limited direct services.

Prevention programming is decentralized, with most programs provided by local schools, counties, courts, and private organizations. The state is divided into planning districts for funding and administration.

Direct services provided by the division include mass media campaigns, model curriculum development, audio-visual lending library, research and evaluation, and training. In addition, it sponsors the statewide Governor's Youth Council on Alcohol. For more information, contact:

Division of Alcoholism and Drugs
120 North 200 West, 4th Floor
Salt Lake City, Utah 84103
F. Leon Povey, Director
(801) 538-3939

Vermont

The Alcohol and Drug Abuse Division Intervention Program provides funds and oversees prevention efforts in the state. Nine regionally based intervention specialists, supported by central staff, plan, develop, follow up, and evaluate a variety of prevention programs jointly with local individuals and groups. Programs are aimed at the general public, schools, workers, and grass-roots organizations.

The division funds about ninety rural, community-based programs each year. In addition, it plans statewide initiatives such as public service announcements and other large-scale projects. For more information, contact:

Office of Alcohol and Drug Abuse Programs
103 South Main Street
Waterbury, Vermont 05676
Richard Powell II, Director
(802) 241-2170

Virginia

The Virginia program is a statewide initiative designed to train student leaders to develop school-based peer resistance programs for prevention of alcohol and drug abuse and for the reduction of alcohol-related accidents among teens. Major features include state training for more than 400 youth and 200 adults, and fifteen regional conferences and two state conferences on alcohol and drug abuse.

In 1986, the state developed a pilot Drug Abuse Resistance Education program. The primary focus is teaching elementary students general skills for coping with life and instructing students in ways to apply these skills to specific events that may threaten their general health. The program is funded by a grant from the Criminal Justice Service for $69,000 and is a cooperative effort between the State Police and the Department of Education. A uniformed police officer is assigned to teach the program fulltime in the classroom. For more information, contact:

Division Office of Substance Abuse Services
P.O. Box 1797
Richmond, Virginia 23214
Wayne Thacker, Director
(804) 786-3906

Washington

The Prevention/Early Intervention Program of the Bureau of Alcohol and Drug Abuse Prevention allots funds to thirty-five county units for the development of local plans. These county plans must be geared toward three types of projects: comprehensive K-12 school-based curriculum that includes knowledge, decisionmaking, coping skills, and self-esteem; student assistance programs; and community organization, which includes parent education and support groups.

The focus of the programs is establishing a partnership between state, county, schools, youth, parents, service organizations, business and industry, churches, etc. For more information, contact:

Bureau of Alcohol and Substance Abuse
Mail Stop OB-44W
Olympia, Washington 98504
Glen Miller, Director
(206) 753-5866

Wisconsin

The Department of Health and Social Services' Office of Alcohol and Other Drug Abuse is the single state authority for prevention programs. Wisconsin has experienced a growth in the areas of community development core group citizen initiatives. This model has become the basis for alcohol and other drug abuse prevention in social policy formulation, citizen/parent action, school curriculum, and intervention programs.

Volunteer involvement has grown at the community and state level, as well as in the workplace and in the Native American reservation community.

There are more than sixty public school districts that have prevention and early intervention programs. For more information, contact:

Office of Alcohol and Other Drug Abuse
P.O. Box 7851
Madison, Wisconsin 53707
Larry Monson, Director
(608) 266-2717

West Virginia

The Division on Alcoholism and Drug Abuse, of the Department of Health, is the single state agency for alcoholism and drug abuse programs. It contracts with fourteen comprehensive community behavioral health centers to provide services.

Prevention activities include working with schools, participating in MADD and SADD groups, coordinating Chemical People task forces, and conducting media campaigns.

The division funds several innovative programs and public awareness campaigns, including D.A.N.C.E. (Drugs are Not Constructive Entertainment), a media campaign and social events for teens; and prevention and early intervention for high-risk populations, specifically family members of alcohol abusers and high school students in driver education classes. Other programs are Project Integrity, a training program for dealing with substance abuse problems of the elderly; peer facilitator training for junior high, high school, and college students; the Natural Helpers Project; and the Youth Outdoor Development Project, a summer employment/personal development program for high-risk youth. For more information, contact:

Division of Alcohol and Drug Abuse
State Capitol
1800 Washington Street East
Charleston, West Virginia 25305
Jack Clohan, Jr., Director
(304) 348-2276

Wyoming

The Office of Substance Abuse Programs, which is within the Division of Community Programs, funds and oversees prevention activities in the state. Programs are administered at the local level by both mental health agencies and free-standing substance abuse agencies. State funding is based on the number of hours of staff time expended rather than on a per capita basis.

There are about twenty-five agencies in the state that provide some degree of prevention service. Each agency devises annual program goals and strategies to meet local needs. For more information, contact:

Office of Substance Abuse Programs
2300 Capitol Avenue
Cheyenne, Wyoming 82202
Jean DeFratis, Director
(307) 777-7115, ext. 6494

PART FOUR: Additional Resources

City Responses To Drug Abuse

This is an annotated listing of drug abuse prevention programs in the Mayors' Clearinghouse on Drug Control. The listing includes community education programs, police-school programs, treatment and counseling programs, municipal employee programs, and community task forces or advisory commissions on substance abuse programs. These listings were last updated in November 1986. For further information on the Mayors' Clearinghouse, contact:

United States Conference of Mayors
1620 Eye Street, N.W., 4th Floor
Washington, D.C. 20006
(202) 293-7330

Alcohol and Drug Abuse Prevention Education: Survey of The States

This report is the product of a joint effort by the National Association of State Boards of Education's (NASBE), Alcohol Education Guidelines Project in collaboration with the Connecticut State Department of Education. This report discusses a policy framework and implementation of alcohol and drug abuse prevention programs in K-12 school programs. It also relates to teaching, monitoring and evaluating programs, and staffing programs in the state education agency. For further information, contact:

The Alcohol Education Guidelines Project
National Association of State Boards of Education
701 North Fairfax Street, Suite 340
Alexandria, Virginia 22314
(703) 684-4000

American Bar Association Policy Recommendation on Youth Alcohol and Drug Problems

This report was adopted by the American Bar Association House of Delegates in July 1985. The report makes recommendations for policy changes dealing with youth and substance abuse prevention. Recommendations are in the areas of: illegal sales of alcohol to minors; youth drug paraphernalia law; dram shop and host liability; child custody and visitation; consent to treatment; and child abuse and neglect laws. For further information, contact:

American Bar Association
Section of Individual Rights and Responsibilities
1800 M Street, N.W.
Washington, D.C. 20036
(202) 331-2273

Strategies for Controlling Adolescent Drug Use

This report from the Rand Corporation by J. Michael Polich, Phyllis L. Ellickson, Peter Renter and James P. Kahan, which gives a detailed analysis of drug use prevention techniques that could curtail drug abuse or prevent the onset of drug use by young people. For further information, contact:

The Rand Corporation
1700 Main Street
P.O. Box 2138
Santa Monica, California 90406-2138
(213) 393-0411

Drug Use Among American High School Students, College Students, and Other Young Adults

This is a study of national trends in drug use among the youth. It gives data on different drugs in different geographical locations and the current trends for drug use. This document is usually updated every two or three years. For further information, contact:

National Institute on Drug Abuse
Alcohol, Drug Abuse, and Mental Health Administration
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, Maryland 20857
(301) 443-6480

State Laws and Procedures Affecting Drug Trafficking Control: A National Overview

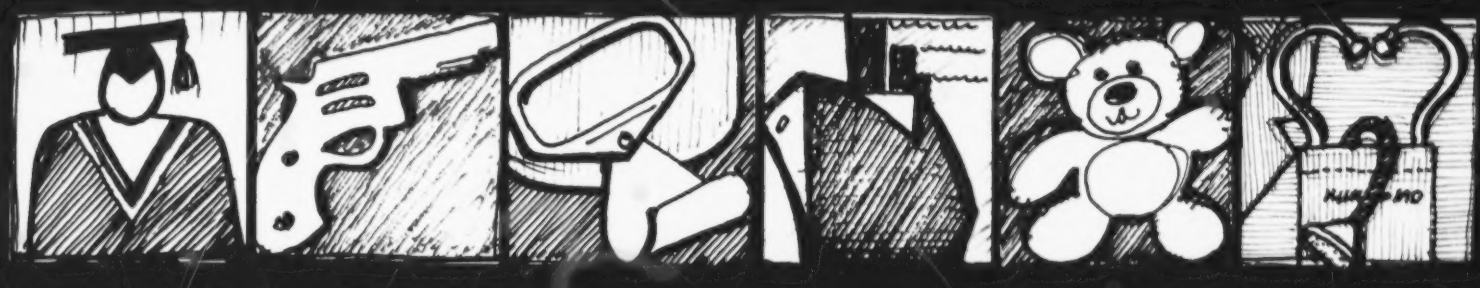
This unique report looks into the aspects of state laws affecting the investigation and prosecution of individuals involved in drug trafficking and related activity. The report covers ten areas: bail, sentencing, forfeiture, group criminality (encompassing conspiracy and racketeering), electronic surveillance, witness immunity and protection, grand juries, currency transaction reporting, state revenue files access, and intergovernmental cooperation (including the sharing of intelligence and statistical data). For further information, contact:

The National Criminal Justice Association
444 North Capitol Street, N.W., Suite 608
Washington, D.C. 20001
(202) 347-4900

State Resources And Services Related To Alcohol And Drug Abuse Problems

This is a profile of state alcohol and drug abuse programs. The information is categorized by: funding levels and sources; client admission characteristics; availability of other treatment-related data; top policy issues; major unmet needs; and significant changes in treatment and/or prevention services. For further information, contact:

The National Association of State Alcohol and Drug Abuse Directors, Inc.
444 North Capitol Street, N.W., Suite 520
Washington, D.C. 20001
(202) 783-6868



NATIONAL GOVERNORS' ASSOCIATION
HALL OF STATES
444 N CAPITOL STREET
WASHINGTON, DC 20001